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ABSTRACT

A survey of 6,000 registered nurses in membership in the Royal College of Nursing across the United Kingdom examined some key factors that determined the supply of nurses. A study of the UK nursing labor market indicated that the number of registered nurses has remained more or less static since the late 1980s. Rising demand appeared to be met by increased working hours and workloads, with an accompanying increase in the proportion of unfilled nursing posts. Analysis of New Earnings Survey data revealed that nurses' earnings remained stable, but consistently below the national average for non-manual workers. Findings showed a rise in turnover for a third successive year. Twenty-two percent of nurses changed jobs or stopped working in the last 12 years. Job satisfaction, ill health, injury, and redundancy accounted for nearly one-third of the job changes. Asked what they expected to be doing in two years, nearly one in five nurses said they expected to leave nursing. The spread of short-term contracts was associated with a rise in perceived job insecurity, even among those on permanent contracts. Although the majority of nurses had caring responsibilities for dependent children or adults, only 20 percent reported employers had "family friendly" policies. Reported shift lengths ranged from 3 to 28.5 hours and the average shift length was 8.9 hours. Over half felt under too much pressure at work. Includes 26 figures and 32 tables. (Appendixes contain 21 references, methodology, and workload scale.) (YLB)

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Summary

This report presents the main findings of a national survey of 6,000 registered nurses conducted in the Spring of 1996. This is the eleventh such survey to be commissioned by the RCN and conducted by the Institute since the mid-1980s. The sample, drawn from the RCN membership, comprises nurses working in NHS hospital and community trusts, including bank nurses, as well as others in GP practices, agencies, nursing homes, occupational health, the independent sector and elsewhere. It also includes those on maternity leave or taking career breaks.

1. The UK nursing labour market

The number of registered nurses employed by the NHS has remained more or less static since the late 1980s. Over the same period reduced length of stay and increased bed occupancy has led to higher patient dependency and an increased demand for qualified nursing inputs. With static workforce growth, rising demand appears to be met by increased working hours and workloads. Independent survey data also show an increase in the proportion of unfilled nursing posts in the NHS.

Nurses' participation rates have also risen, with the bulk of recent employment growth coming in the private nursing homes sector. As a result the private sector now accounts for more than a quarter of the nursing workforce, and the pool of potential returners is probably no more than 20,000.

Intakes to pre-registration nurse education have fallen by 39 per cent since the late 1980s. As a consequence, the number of new entries to the UKCC register has reduced to little more than 17,000 a year, with the effect of more recent cuts still to feed through. More than a fifth of those on the Register are now aged 50 or over.

The NHS Executive has begun to reverse the decline in pre-registration intakes. The number of education places commissioned over the next three years is forecast to rise. However, this will not feed through into the workforce until the next century. In the meantime, effective strategies to improve recruitment, retention and staff morale are essential.

2. Nurses' pay

Analysis of New Earnings Survey data reveals that nurses' earnings have remained stable, but consistently below the national average for non-manual workers, throughout the 1990s. In 1995 they were at their lowest since clinical grading was introduced.

This is reflected in the declining pay satisfaction shown by respondents to successive surveys. The proportion of NHS nurses agreeing that they could be paid more for less effort if they left nursing has risen from 45 per cent in 1992 to 63 per cent in 1996. Nurses working outside the NHS share this view.

The vast majority (87 per cent) of NHS nurses also agree that they are poorly paid in relation to other professional groups.

The responses of nurses to statements about the principle and practice of local pay are unequivocal. The majority remain unconvinced. Few (13 per cent) believe that it will reward high quality nursing; most (85 per cent) believe that it will increase uncertainty and most (86 per cent) believe that it will result in unfair deals for some nurses. These results suggest that managers have so far been unable to allay the concerns of staff which were alluded to in the last Review Body report.

In recent years, the annual incremental rise, for eligible NHS nurses, has been the main source of pay increase. Now, two-thirds of all NHS nurses (and 88 per cent of enrolled nurses) are on the top increment of their scale and are no longer eligible for incremental pay rises.

3. Turnover, wastage and retirement

Evidence from the IES survey shows a rise in turnover for a third successive year. Twenty-two per cent of NHS nurses changed jobs or stopped working in the last twelve months. This compares with figures of 20 per cent and 15 per cent during 1994 to 1995 and during 1993 to 1994 respectively. Most of this turnover is accounted for by nurses moving between posts within the NHS. Turnover is particularly high among the recently qualified; half of those registering in the last three years changed jobs during 1995 to 1996.

The NHS labour market is becoming more volatile. Thirty-seven per cent of those who changed jobs within the NHS also changed trusts. Few of these moves were accompanied by grade changes. The comparable figure for 1995 was 27 per cent.

Job dissatisfaction, ill-health, injury and redundancy account for nearly a third of the job changes within the NHS. Wastage from NHS nursing has also risen, from five to six per cent.

Half of the leavers remain in direct care nursing, with the independent sector being their main employer. Twenty-three per cent of NHS leavers said that job dissatisfaction was their main reason for leaving. More than a third (37 per cent) of those who left because of job dissatisfaction had first registered since 1990; the majority (71 per cent) are still in nursing jobs.

Retirement and early retirement account for an increasing proportion of leavers; more than one in ten compared with seven per cent during 1994 to 1995. This proportion is likely to increase as more nurses come within the scope of the NHS Pension Scheme's early retirement arrangements. Excluding ill-health retirements, almost half of those who retired were aged under 55.

Asked what they expected to be doing in two years' time, nearly one in five NHS nurses said they expected to leave the service. Over half of those who expect to leave are aged under 35. An increasing proportion of nurses agree with the statement *'I would leave nursing if I could'*. This has grown from 25 per cent in 1993 to 38 per cent in 1996.

4. Recruitment, retention and return

Permanent employment has been the traditional norm in the NHS, with temporary bank and agency staff being used as an additional 'flexible' component. However, the survey indicates that five per cent of NHS nurses were employed on short-term contracts, up one per cent on the 1995 figure. A quarter of those who joined the NHS in the last year were employed on temporary contracts.

Almost half of those on short-term contracts have been with the same employer for more than a year. This seems to confirm the Review Body's own perception that some trusts were using such contracts as a matter of policy, even where posts were expected to continue.

The spread of short-term contracts is associated with a rise in perceived job insecurity, even among those on permanent contracts. Only 16 per cent of NHS nurses agreed with the statement *'Nursing will continue to offer me a secure job'*. More than a third said that they were worried about being made redundant.

The majority of NHS nurses in this survey have caring responsibilities for dependent children or adults. However, only 20 per cent report that their employers have 'family friendly' policies which enable them to combine work and caring responsibilities more readily. The proportion of job-share posts has remained unchanged since the late 1980s. Few nurses have formal career break schemes and less than three per cent of those with dependent children make use of after school/holiday play-schemes. Only four per cent use a workplace nursery or crèche.

The low take-up of such arrangements among those in the workplace suggests few trusts have effectively adopted employment practices which would satisfy the expectations of those currently out of paid employment who want to return to nursing.

5. Working hours and workloads

There is wide variation in reported shift patterns. Internal rotation is the most prevalent shift pattern worked by NHS nurses (32 per cent), while a large minority (39 per cent) of non-NHS nurses report working only early or late shifts. There has also been a slow rise in the proportion of NHS nurses who report working a 12 hour shift pattern, from two per cent in 1993 to five per cent in 1996. Meanwhile, 12 hour shifts have fluctuated around two to three per cent in the non-NHS sector over the same time period.

Reported shift lengths for all respondents range from three hours to 28.5 hours and the average shift length for NHS and non-NHS nurses is 8.9 hours. The average shift length worked by NHS nurses varies by field of practice. There is little difference between reported shift length and shift patterns except for night shifts: night shifts are on average two hours longer than other shift patterns.

Nearly a fifth (18 per cent) of NHS nurses report that they did not have a rest period during their last shift. A large minority (40 per cent) also report that they had less than 11 hours off between their last two shifts because of shift work, *ie* internal rotation or early or late shifts.

The majority of respondents (60 per cent) report working 37.5 hours or less in their last full working week. However, the proportion of full-time NHS nurses who report working more than the 48 hours in their last full working week has almost doubled from ten per cent in 1995 to 19 per cent in 1996.

More than half of NHS nurses report working in excess of their contracted hours, which is similar to findings in 1995. However, the sum total of excess hours has increased by 39 per cent. Overall there has been a decline in paid remuneration for excess hours working.

The proportion of NHS nurses reporting additional bank work has doubled from 23 per cent in 1995 to 50 per cent in 1996. The average number of bank hours worked has also increased by one hour from 7.7 hours in 1995 to 8.8 hours in 1996.

Over half (56 per cent) of NHS nurses *'feel under too much pressure at work'*: only a third (35 per cent) agreed with this statement in 1992. The majority (82 per cent) of NHS nurses are dissatisfied with perceived workloads, and nearly half (45 per cent) would leave nursing if they could; four out five would not recommend nursing as a career.

1. The UK Nursing Labour Market[1]

This report presents the main findings of a survey of registered nurses in membership of the Royal College of Nursing (RCN) across the UK. It is the first in a new series of three annual surveys commissioned by the RCN in February 1996. Similar surveys have been commissioned by the RCN, and conducted by the Institute for Employment Studies (IES) annually since 1986. This survey was conducted between late March and mid-May 1996 by IES, an independent research and consultancy organisation.

Anecdotal evidence about nurse staffing shortages in particular specialties or trusts has been prominent in the media for much of this year. Robust, national data on the nature and extent of such shortages is, however, more difficult to identify. Nevertheless, the weight of evidence increasingly points to problems in balancing the supply of, and demand for, registered nurses.

The NHS Executive acknowledges the potential for future shortages, at least in the case of adult/general and mental health nurses, in its planning guidance for 1996/97 which states that: *'... long term trends suggest that current levels of training are unlikely to produce the number of qualified staff required unless there is a substantial reduction in demand for nurses.'* (NHS Executive, EL (95) 96, para. 2.1, August 1995)

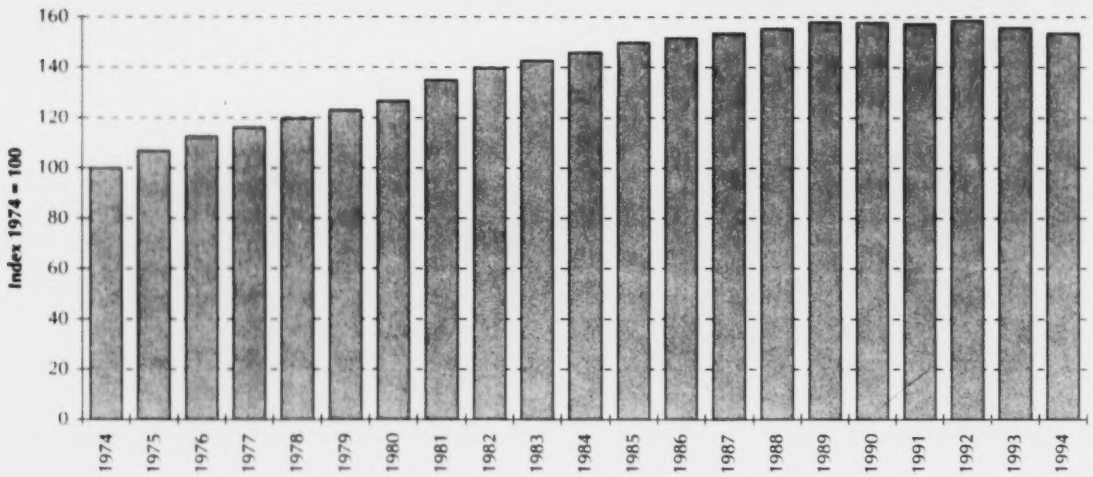
This report examines some of the key factors which determine the supply of registered nurses, drawing on detailed survey evidence to do so. In this first chapter, we present an overview of nurse supply and demand, drawing on available national data.

1.1 The demand for nursing care

On the demand side, the overall number of registered nurses employed by the NHS in Great Britain has remained comparatively unchanged since the late 1980s (see Figure 1.1 overleaf) with a long-term trend in growth at around four per

[1] The material presented in this section is explored in more detail in Buchan J and Seccombe I (1996 forthcoming) *The UK Nursing Labour Market*, IES/RCN

Figure 1 : 1 Change in WTE numbers of registered nurses and midwives[1] employed by the NHS, 1974 to 1994 (Great Britain)



[1] Hereafter, the term registered nurse refers to any registered practitioner on the UKCC register.

Source: IES 1996/Annual Abstract of Statistics

cent per year between the mid-1970s and the mid-1980s. The most recently available data (1994) show that the NHS in Great Britain employs some 291,029 (WTE) registered nurses and midwives, a reduction of 8,498 (2.8 per cent) on the 1989 workforce.

The lack of growth in recent years has occurred despite a continued increase in NHS activity levels and a rise in nurse participation rates. Data from the Labour Force Survey shows that participation in nursing employment, of those whose highest qualification is nursing, has risen from 54 per cent in 1992 to 57 per cent in 1995 (for further discussion of participation rates see section 4.1 below).

Increasing participation rates in the late 1970s and early 1980s offers an explanation as to why general nursing shortages did not emerge earlier, despite the growth in nursing employment outside the NHS. One consequence of the reductions in intakes in the last few years is that the pool of potential returners in ten to 15 years time will also be diminished.

The bulk of this recent employment growth has been in the private nursing homes sector (see 1.1.2 below). Projections of the increase in the elderly population, coupled with the transfer of long stay beds out of the NHS, rising proportions of elderly home owners, and falling numbers of carers, are likely to mean a continuing demand for private nursing home and community nursing services.

One indicator of unmet demand for nursing care is the annual Office of Manpower Economics (OME) survey of nursing vacancies (NURVAC). There are a number of problems with the

Table 1 : 1 Registered nurses: vacancies, frozen posts and posts held permanently open, as a percentage of establishment 1991 to 1995

	Vacancies	Frozen	Permanently open
1995	3.3	0.2	0.8
1994	2.8	0.3	0.9
1994	2.8	0.4	0.9
1993	2.9	0.6	0.2
1993	3.1	0.6	0.3
1992	4.0	0.3	n.a.
1992	4.0	n.a.	n.a.
1991	4.6	n.a.	n.a.

Source: Review Body reports

collection and interpretation of these data and these have been frequently aired elsewhere[1]. Table 1.1 uses data from the matched samples reported by the OME.

These data show an increase in the proportion of vacant and 'permanently open' posts over the last two years, and a decline in the proportion of posts reported as frozen. Combining these three categories (for matched samples) reveals a nine per cent growth in the totality of unfilled posts between March 1994 and March 1995, and a shift away from frozen posts.

Within the NHS acute sector, reduced length of stay and increased bed occupancy may have led to higher levels of patient dependency and an increased demand for qualified nursing inputs. The effects of these changes on nurses' working hours and workloads are considered below (see chapter 5.2.5 and 5.2.6).

Many units, particularly in the acute sector, have conducted skill mix and re-profiling exercises in recent years. There is as yet no indication from official data that these had led to an aggregate and substantial reduction in the use of registered nurses. A recent IES survey of trust nurse executive directors reported that many directors did not foresee substantial shifts away from registered nurses. Indeed, a third of respondents indicated that their 'ideal' mix would require a higher, rather than lower, proportion of registered nurses (Buchan, Seccombe and Ball, 1996 forthcoming).

Reductions in junior doctors' hours and the implementation of the Calman proposals for medical training grades, which are expected to result in the transfer of some activities from junior doctors to nurses, also suggests that NHS demand for registered nurses is unlikely to diminish in the medium term.

[1] See: Nursing and Midwifery Staffs Negotiating Council, Staff Side (1995), *Evidence to the Review Body 1996.*

Table 1 : 2 Entries to pre-registration nursing courses 1987/88 to 1995/96, by country[1]

	England		Scotland		Wales		Northern Ireland		UK	
	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2
1987/88	15,202	2,597	2,638	585	983	199	787	24	19,610	3,405
1988/89	15,905	1,682	2,734	529	892	135	854	1	21,221	2,347
1989/90	15,797	587	2,837	399	993	47	815	0	21,117	1,033
1990/91	15,452	62	2,779	204	1,010	74	697	0	20,676	340
1991/92	16,864	0	2,146	84	712	0	745	0	21,406	84
1992/93	15,921	0	2,348	55	945	0	642	0	20,694	55
1993/94	12,464	6	2,377	27	871	0	528	0	16,737	33
1994/95	10,301	0	2,230	9	705	0	466	0	14,025	9
1995/96	n.a.	0	n.a.	0	n.a	0	476	0	n.a	0

(n.a. = not available)

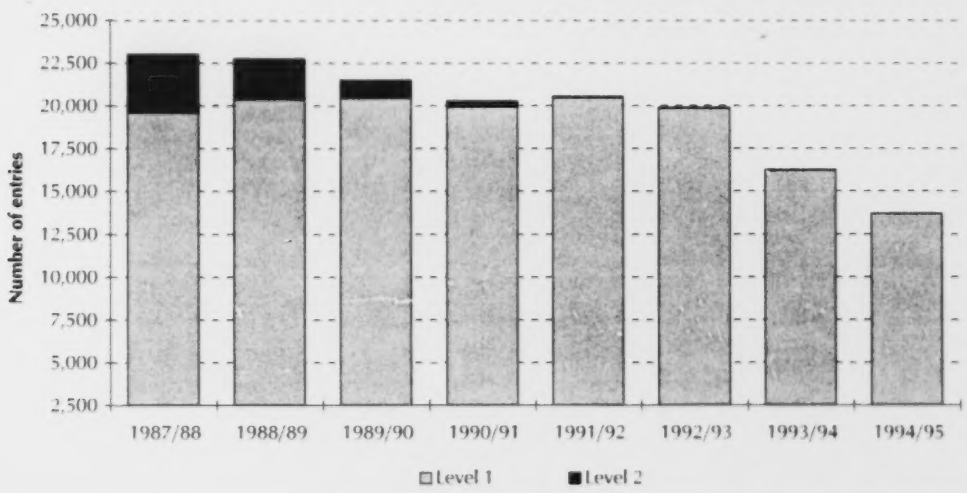
[1] Note: these data exclude intakes to EN conversion courses and post registration courses; data for England includes re-entries

Source: IES/National Boards

1.2 Trends in nurse supply

On the supply side, there has been a marked fall over the past decade in the intakes to pre-registration education in each of the four countries (Table 1.2). Figure 1.2 shows that intakes to first level nursing courses fell from 19,610 in 1987/88 to 14,025 in 1994/95. In the same period, entrance to level 2 courses ceased altogether. The overall effect was a reduction in intakes to pre-registration nurse education in the UK of more than 8,900 (or 39 per cent).

Figure 1 : 2 Intakes to first and second level pre-registration nursing 1987/88 to 1994/95



Source: IES/National Boards

Table 1 : 3 New Entries to the UKCC Professional Register from the UK, 1989/90 to 1994/95

	89/90	90/91	91/92	92/93	93/94	94/95
England	15,265	14,786	14,184	13,931	13,992	13,997
N. Ireland	738	659	726	717	707	585
Scotland	2,560	2537	2513	2485	2334	2060
Wales	973	998	846	936	915	769
Total	*19,536*	*18,980*	*18,269*	*18,069*	*17,948*	*17,411*

Source: IES/ UKCC Statistical Analysis of the Council's Professional Register

The effects of these reductions in the numbers in nurse education are shown in the falling levels of new entries to the UKCC register. Table 1.3 shows that new entries from the UK fell by 2,125 (11 per cent) between 1989/90 and 1994/95. Over this period, the numbers entering the register from pre-registration education in Northern Ireland fell by 21 per cent, by a fifth (20 per cent) in Scotland and by 21 per cent in Wales. One consequence of the large cutbacks in nurse education in Northern Ireland is that traditional flows of nurses from the province into the NHS in England may diminish.

The number of nurses on the UKCC effective register has grown by just over three per cent in the last five years, to stand at 642,951 in 1994/95. This compares with a six per cent rise between 1988/89 and 1990/91. The number on the register in 1994/95 increased by 4,590 (a 0.7 per cent rise) following a half per cent drop (3,388) in 1993/94 (see Table 1.4 overleaf).

Further reductions in the number registered can be expected as the effects of smaller intakes to training between 1992/93 and 1995/96 feed through into smaller numbers qualifying and becoming eligible to register between 1995/96 and 1998/99. The possible effects of the introduction of PREP on the size of the potential pool are too early to judge; but this may also contribute to a fall in the numbers on the register. [1]

The average age of those on the register is also rising, with 20 per cent now aged 50 or over (compared with 18 per cent in 1991). This inevitably means that wastage from retirement will increase (see section 3.2.4 below). At the same time, the number (and proportion) under age 30 is dropping (from 26 per cent in 1991 to 19 per cent in 1995).

For the NHS these key trends — a diminishing supply of newly qualified nurses, an ageing nurse population, and a reducing

[1] The recent (June) decision by the UKCC that standards for PREP should recognise 'unwaged experience', and that 'practice' will include the unpaid delivery of nursing care to a friend, relative or dependent (provided that it satisfies certain criteria) may reduce this effect. See: 'Unpaid experience to be recognised by UKCC', *Nursing Standard*, June 19, p.15.

Table 1 : 4 Number of nurses on the UKCC effective register, 1988/89 to 1994/95

	Number of nurses on the effective register
1988/89	584,753
1989/90	607,103
1990/91	622,001
1991/92	633,119
1992/93	641,749
1993/94	638,361
1994/95	642,951

Source: IES/ UKCC Statistical Analysis of the Council's Professional Register

pool of potential returners — are reinforced by recent growth in non-NHS employment. Table 1.5 (below) shows the growth in the number of registered nurses employed by General Practitioners in England and Wales, from 2,326 (WTE) in 1985 to 10,616 in 1995.

Between 1984 and 1994 the private sector (hospitals and nursing homes) increased its share of the total (WTE) nursing workforce (excluding learners) from eight per cent to 26 per cent. The numbers of registered and enrolled nurses in this sector grew from 15,900 (WTE) in 1984 to 54,636 (WTE) in 1994[1]. Indeed, it is primarily the growth in this sector which explains the rise in nurse participation rates at a time of static employment growth in NHS nursing. Since a high proportion of non-NHS nurses

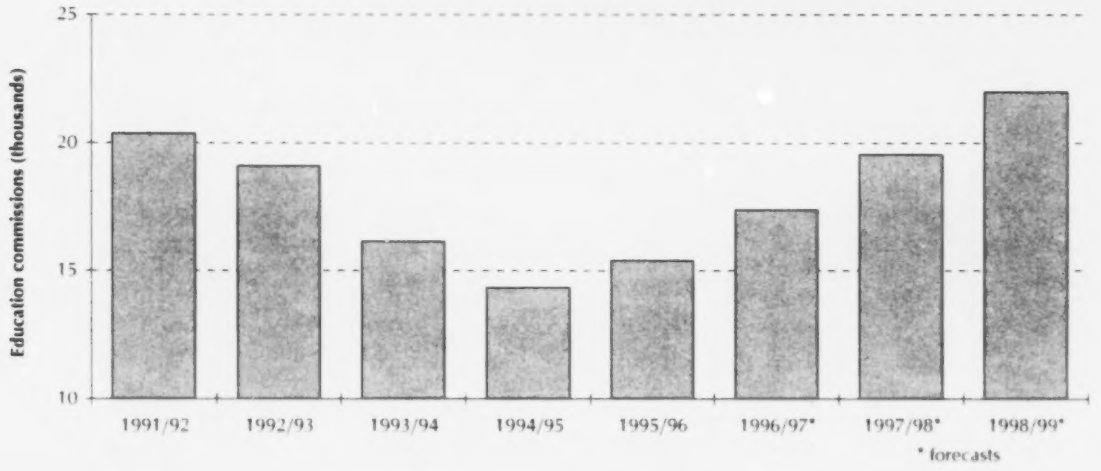
Table 1 : 5 Number of practice nurses in England and Wales (WTE) 1985 to 1995

	England	Wales
1985	2,211	115
1986	2,501	140
1987	2,768	167
1988	3,480	194
1989	4,632	268
1990	7,738	418
1991	8,776	524
1992	9,121	519
1993	9,605	552
1994	9,099	544
1995	9,996	620

Source: IES/GMS census (annual)

[1] *KO36: Private Hospitals, Homes and Clinics registered under section 23 of the Registered Homes Act 1984* — Department of Health.

Figure 1 : 3 Actual and forecast education commissions 1991/92 to 1998/99 (England)



Source: IES/NHS Executive, Workforce Balance Sheet Exercise

work part time (36 per cent) this increase in WTE employment means an even greater increase in the headcount number.

The reduction in pre-registration numbers is now being reversed (see Figure 1.3). Forecast education commissions (including degrees, conversion and post-registration qualification) for 1996/97 are around 14 per cent higher than in 1995/96.

The NHS Executive has indicated that *'A further substantial increase in training will be needed if future demand for qualified nurses grows'*.[1] The Executive Letter issued in June 1996, suggests that early results from its national workforce modelling project indicate that an additional 4,000 training places for 'basic nurse training' will need to be commissioned nationally, to match the forecast demand from 2001. It hints that increasing commissions by about 12.5 per cent in 1997/98 and again in 1998/99, should provide *'sufficient newly qualified nurses to meet demand across the healthcare sector into the next century'*.

In addition to the decline in the numbers of new entrants into nursing, there is evidence, which we discuss below (section 4.1) that participation rates among registered nurses are high, and that the scope for further increases is probably negligible. Data from the Labour Force Survey for Winter 1995/96 (December 1995 to February 1996) shows that 83.5 per cent of those whose highest qualification is 'nursing' are in employment (and 57 per cent are in nursing employment); 15 per cent are inactive and 1.5 per cent are unemployed. The pool of qualified nurses genuinely available for nursing work is limited, since only one in five of the inactive group are seeking or would like work, and this is not necessarily in nursing.

[1] NHS Executive, EL (96) 46, June 1996.

Table 1 : 6 Registered nurses leaving the NHS — England only (per cent)

	Registered nurses, district nurses and health visitors	Enrolled nurses and district enrolled nurses
1992/93	7.6	7.0
1993/94	8.8	8.1
1994/95	9.2	10.1

Note: figures for 1992/93 exclude S.E. Thames and N.W. Thames RHAs.

Source: Department of Health, KM48 return

Available evidence appears to indicate an increase in wastage from NHS nursing. Table 1.6 shows that wastage rates have risen since the early 1990s, to 9.2 per cent of registered nurses and 10.1 per cent of enrolled nurses in 1994/95 — the last period for which this information was collected. The Department of Health consider that this trend may be more apparent than real, reflecting improving coverage and response. The trend in wastage is examined in detail in Chapter 3 below.

It could be argued that shortfalls in nurse supply can be met by increased reliance on overseas nurses in the same way that the NHS has traditionally relied on doctors who qualified abroad (currently more than 20 per cent). In practice, the UK appears to be diminishing as a destination for nurses who qualified in Australia and New Zealand, traditionally the main sources of overseas supply to the UK (Buchan, Seccombe and Thomas, 1996 forthcoming). Restrictions on the granting of work permits to nurses (by the removal of nursing from its classification as a 'shortage' occupation) mean that entry from outside the EU is likely to be reduced further. Within the EU, the Health Ministers have agreed that each country will aim for self-sufficiency. NHS employers are therefore more likely to seek recruits from outside the EU.

To obtain a work permit, employers need to demonstrate that they have advertised, without success, in the UK over the last six months. The need to advertise is currently waived for certain groups of nurses (mental health, learning disabilities, theatre, ITU and neonatal care).

Applications to the UKCC for admission to the register from nurses who qualified abroad, have more than halved since 1990/91, dropping to 3,500 in 1994/95.[1] Admissions to the UKCC register from abroad have also been reducing since the early 1990s, and fell by 23 per cent between 1991 and 1995. Moreover, not all those who register actually work in nursing.

[1] UKCC (various years) *Statistical Analysis of the Council's Professional Register.*

1.3 Commissioning nurse education

The cutbacks in intakes to pre-registration nurse education reflect the outcomes of the 'balance sheet' commissioning exercise. Introduced in 1991, the purpose of the balance sheet is to *' . . . ensure that regions are making a fair contribution to the education and training of staff groups covered . . . '*[1] and that national supplies are maintained. Regional Health Authorities (now NHS Executive Regional offices) aggregated the workforce plans of NHS and other healthcare providers, to give an overall estimate of demand for education places.

There are several reasons why the balance sheet led to reductions in the number of places commissioned, despite the apparently rising demand for nursing care. These include a number of labour market characteristics:

- Prior to the introduction of Project 2000, hospital employers had an incentive (access to a comparatively cheap labour supply) to keep student numbers high. Project 2000 introduced the supernumerary status of pre-registration nursing students and reduced their workforce contribution, thus reducing this incentive.
- This also encouraged employers to guarantee employment to these students on qualification, rather than to recruit more experienced, less 'flexible' and more expensive, returners from the pool.
- Demand for new qualifiers, in the NHS hospital sector, is now more likely to be based on the actual level of D grade vacancies — until recently, these vacancy levels may have been depressed by comparatively low turnover and wastage and by enrolled nurse conversions.
- In contrast, NHS community units have traditionally sought to recruit experienced nurses (from the pool) into Health Visiting and District Nursing— as a result, they too tend not to identify a current demand for newly qualified nurses.
- The rapid, and largely unanticipated, growth of employment in GP practice and independent sector nursing — which has been fed from the, now depleted, pool.

In addition, there are more technical limitations to the process. These include:

- Few employers have reliable historic data on wastage upon which to base projections. As a result, short-term trends (which have been influenced by recession) tend to be more influential. Employers with higher than average wastage tend to assume that they will improve retention; those with lower than average wastage continue to forecast low levels.

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[1] *Balance Sheet Guidelines 1994/95*, Yorkshire Health.

- Some employers may also have built into their plans assumptions about skill mix which have not been realised.
- The short-term nature of service contracting makes it difficult to project future workforce requirements over a sufficient period — demand for new qualifiers is therefore more likely to be based on current vacancy levels and wastage assumptions.
- The growth in the number of fundholding GPs adds to this uncertainty.
- Some non-NHS employers were unwilling, or unable, to take part in the exercise.

New arrangements for the workforce planning which underpins the commissioning of education places (in England), were introduced in April 1996. These new arrangements are intended to give purchasers and employers (including non-NHS providers) greater responsibility for planning and commissioning non-medical education and training.[1] The new framework for workforce planning and education commissioning, provides for two new structures:

- Education and Training Consortia (ETCs)
- Regional Education and Development Groups (REDGs).

ETCs are geographically based groups (between four and eight in each region) of healthcare purchasers, NHS providers, GPs and non-NHS providers. Their principal role is to collate workforce plans, to determine demand for non-medical education places, and to commission such places from education providers.

REDGs comprise representatives of each consortium within an NHS Region, together with NHS Executive Regional Office representatives. Their role is to advise on the acceptability of the consortia plans.

It will be some time before these new arrangements can be properly evaluated, and it remains to be seen as to whether they can successfully overcome the problems which have influenced the outcomes of the balance sheet exercise in the past.

1.4 Nursing shortages

Taken collectively, the evidence considered here points to a growing imbalance between the supply and demand of registered nurses. These factors include:

- trends in demand
- the diminishing supply of newly qualified nurses

[1] The new arrangements are described in detail in EL (95) 27, March 1995.

- the ageing nurse population and, in particular, the approaching retirement 'bulge'
- the low level of nurse unemployment and the high rates of participation within the sector
- the limited scope for recruiting abroad.

The NHS Executive's Education and Training Planning Guidance issued in June 1996 concedes that there are problems in some 'specialist areas' and identifies the potential for more widespread shortages. Para. C 1.3 of EL (96) 46 notes that: *'Indications are that current training levels are insufficient to meet future demand for qualified nurses.'* While para. C 1.4 recognises that this cannot be solved in the short term: *'The number of newly qualified staff available until 2001 has been set by the number of training places which have already been commissioned. Increases in training will not begin to emerge until the next century. Short-term pressures on the qualified nursing workforce will need to be addressed locally by employers improving recruitment and retention and persuading more trained staff to return to the profession.'*

The long lead times in nurse education inevitably mean that it takes several years for any increases in the numbers entering education to work through into the labour market. In the meantime the available pool is limited. Strategies to improve recruitment, retention and staff morale are clearly essential to ameliorate the effects of any actual or potential shortfall.

The remainder of this report presents the key findings of a survey of registered nurses in full membership of the Royal College of Nursing (RCN) across the UK. The survey was conducted between late March and mid-May 1996. Almost 80 per cent of the 6,000 nurses contacted, replied to the survey. Full details of the survey methodology and response rates are contained in Appendix A.

1.5 Respondent profile

This section briefly outlines the key demographic, biographical and employment characteristics of the survey respondents.

Table 1.7 (overleaf) compares the distribution of survey respondents with those on the UKCC effective register (resident in UK) and with the latest available Labour Force Survey data. The distribution of the survey respondents corresponds almost exactly with these independent sources.

The age distribution of respondents is broadly similar to that of the effective UKCC register (see Figure 1.4 overleaf). Respondents to the current survey were selected on the basis that they were paying a full membership subscription to the RCN and not a reduced fee, for example, because of retirement. UKCC registration is renewed every three years and nurses who retire

Table 1 : 7 Distribution of survey respondents by country of residence compared with the UKCC register and the Labour Force Survey (UK only)

	IES/RCN survey	UKCC register	Labour Force Survey
England	79%	79%	79%
Scotland	11%	12%	11%
Wales	6%	5%	6%
Northern Ireland	3%	3%	4%
Base number	*4,377*	*597,495*	*535,715*

Note: percentage figures in this and subsequent tables may not sum to 100 because of rounding.

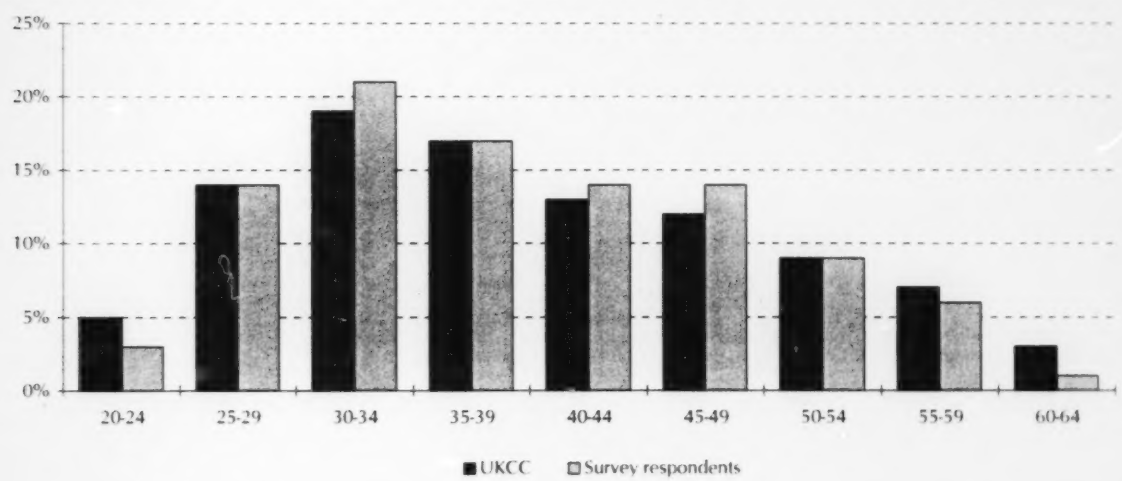
Source: IES/UKCC/LFS

remain on the register until their registration becomes renewable. This accounts for the higher proportion of nurses aged 60-64 years of age. The survey's smaller proportion aged less than 25 reflects the fact that newly qualified nurses may remain as student members for one year and are therefore excluded from the sample.

The proportion of NHS nurses aged under 30 years has declined from 34 per cent in 1992 to 20 per cent in 1996. The average age of all respondents was 39 years. NHS nurses were significantly younger than non-NHS nurses. The average age of NHS nurses was 37 years, compared with 41 years for non-NHS nurses.

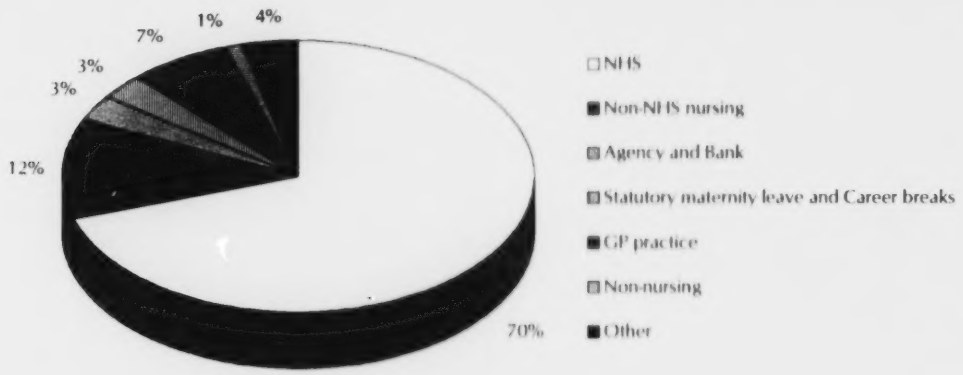
Within NHS nursing in England, the survey shows that seven per cent of respondents are men. This is the same as the figure reported by the Policy Studies Institute in 1995 (Beishon, 1995). Eighty per cent of respondents currently working in nursing were married, 42 per cent had dependent children under 16

Figure 1 : 4 Age distribution of respondents compared with the effective UKCC register



Source: IES/UKCC

Figure 1 : 5 Survey respondents by employment



Source: IES 1996

years of age, and 16 per cent had a regular caring responsibility for an elderly relative or other adult.

NHS nursing was the predominant employment sector of respondents to the present survey, accounting for 70 per cent of all respondents and 73 per cent of those in nursing employment (see Figure 1.5 above). Thirteen per cent of those in nursing employment were in non-NHS nursing jobs, others worked as bank, agency or GP practice nurses. The pattern of employment by sector is broadly the same as that found in 1995, with two main exceptions:

- the proportion of respondents in permanent agency and bank nursing employment has declined from four per cent in 1995 to three per cent in 1996 (although the amount of bank nursing among the NHS nursing workforce has increased — see 5.2.7 below)
- the proportion reporting non-nursing work has declined to under one per cent, compared with two per cent reported in 1995.

These are, however, very marginal changes based on comparatively small numbers of respondents. They should therefore be interpreted cautiously. Nevertheless, they agree with independent evidence of a shortfall in supply from nursing agencies and with evidence of rising participation in nursing.

Of the remaining respondents, two per cent were on long-term sick leave, retired, or working in a job which utilised nursing skills. The proportion unemployed but seeking work was the same for both 1995 and 1996: less than one per cent.

The majority of respondents (60 per cent) reported working full time. Over a third (37 per cent) reported part-time working, with the remaining three per cent undertaking job shares or

occasional employment. Working patterns varied across work settings (see section 5.2.1 below). The proportion of NHS nurses working full time (64 per cent) has declined slightly since 1995 when 66 per cent of NHS nurses reported working full time. There has been a small increase in part-time working to 35 per cent, from 34 per cent in 1995.

The survey respondents in nursing were drawn from the full range of work settings. Just over half worked in acute/general hospitals with nearly one in six employed in community settings, and one in ten in nursing homes.

Respondents also represented a broad range of specialties. Nearly two-fifths were employed in adult acute nursing, and just under a fifth in primary care. Twelve per cent worked in elderly care, six per cent in mental health, and five per cent in paediatrics.

The profile data presented here are consistent with previous surveys of RCN members conducted by IES. We are confident, therefore, that they are representative of the RCN membership as a whole. High response rates to this and previous surveys in the series also mean that we can be confident in comparing data over time.

The profile data are also consistent with data from independent national sources and with the findings of other large scale surveys of nurses. We are therefore confident in drawing inferences between the survey respondents and the wider population of registered nurses.

1.6 Summary

The main points made in this chapter include:

- The number of registered nurses employed in the NHS has remained more or less static since the late 1980s; at the same time, the numbers employed in the independent sector and in GP practice nursing have increased substantially.
- Overall, NHS activity levels have increased and patient dependency levels have risen. Demand for nursing care is expected to rise further in response to demographic trends and changes in junior doctors hours.
- The proportion of posts reported vacant or 'held permanently open' has increased.
- Recent past reductions in intakes to pre-registration nurse education are leading to a drop in the number of new entries to the UKCC register.
- The average age of those on the Register is rising and retirement rates are set to increase; participation rates of

registered nurses have risen and the pool of nurses available for nursing work appears to be constrained.

- Applications to join the Register from abroad have halved since 1990/91, and admissions from abroad have reduced by almost a quarter.
- The NHS Executive has identified actual and potential shortages of nurses and has set out to increase intakes to pre-registration education; these will not impact on the stocks until the next century.

2. Nurses' Pay

2.1 Introduction

This survey was launched after the Thirteenth report of the Review Body for Nursing Staff, Midwives and Health Visitors (the Review Body hereafter) had recommended a two per cent national award for nurses, and claimed that sufficient extra resources were available for trusts to give nurses a ' ... *reasonable local pay increase ...* ' without setting limits.

In practice, local pay negotiations were slow to get under way with only 20 trusts having made offers, and only one having settled, by the time this survey closed. This delay is caused in part by slow contract negotiations between purchasers and providers, the outcome of which will determine the funds which trusts have available, after paying the 6.8 per cent junior doctors increase, to negotiate local pay. Many commentators have argued therefore that the scope for locally negotiated pay in 1996 will be limited (IRS, 1995).

Figure 2.1 illustrates the trends over the period 1977 to 1995 in the average gross weekly earnings of nurses in full-time employment, as a percentage of average non-manual earnings.

Figure 2 : 1 Nurses' earnings during 1989 to 1995 as a proportion of all non-manual earnings

Source: IES/New Earnings Survey, Earnings by Agreement (annual)

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In the mid to late 1980s nurses' earnings were comparatively stable, fluctuating between 72 and 74 per cent of average non-manual earnings. Following the clinical grading review in 1988 there was an increase in nurses' relative earnings, to 84 per cent of the non-manual average. In the first half of the 1990s the relative earnings of nurses continued to show year-on-year fluctuations, but show no improvement over the 1989 figure.

These findings resonate with the analysis of Elliot and Duffus (1996) who show that in 1992, registered nurses lie 19th (male) and 22nd (female) in a ranking of 44 public service sector occupations. Elliot and Duffus also show that earnings differentials in the NHS between hospital doctors and nurses widened substantially during the 1980s and early 1990s.

Recent trends in nurses pay reflect developments in the three components of NHS nurses' pay. These components are:

- the Review Body award which uprates the whole NHS nurses pay structure by a fixed percentage amount
- an amount determined by local negotiation
- an annual incremental increase reflecting individuals' progression within their clinical grade.

This chapter reports the survey findings on each of these components:

- we deal first with the effect that the trends in relative pay have had on nurses' pay perceptions (section 2.2.1)
- we then report nurses' attitudes towards local pay arrangements (section 2.2.2)
- we consider the effects of grade drift on nurses' pay satisfaction and attitudes towards local pay (section 2.2.3)
- finally, we present survey data on non-NHS nurses' pay (section 2.2.4).

2.2 Results

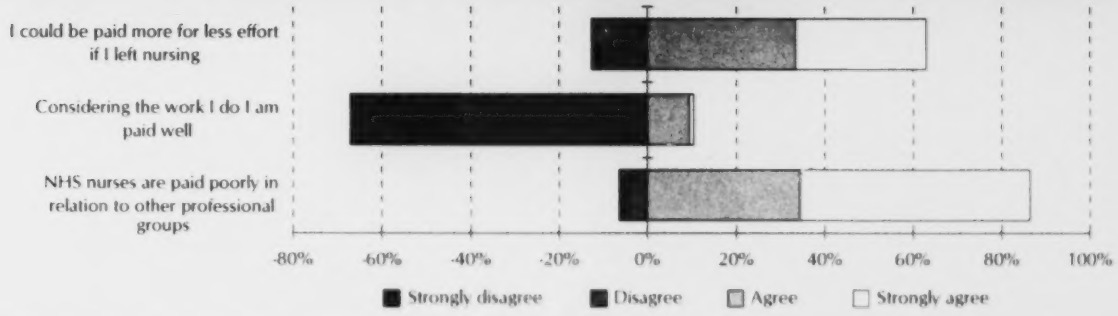
2.2.1 The relative pay of nurses

Respondents were asked to indicate the extent to which they agreed or disagreed with a number of attitudinal items concerning their relative pay. These items were:

- *I could be paid more for less effort if I left nursing*
- *considering the work I do I am well paid*
- *NHS nurses are poorly paid in relation to other professional groups*

These items have been used in each of the last five surveys. Here we present the responses of nurses in 1996 and examine how

Figure 2 : 2 Summary of pay satisfaction items — NHS nurses



Source: IES 1996

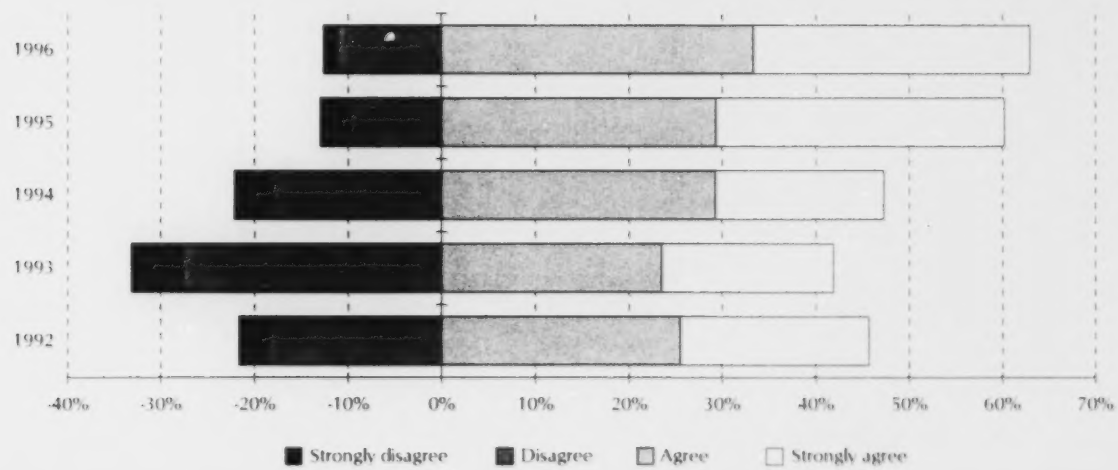
they have changed over time. Figure 2.2 summarises the responses of the NHS nurses in the current survey.

Nearly two-thirds (63 per cent) of NHS nurses agree that they could be paid more for less effort if they left nursing. The proportion agreeing with this statement has increased with each successive survey, rising from 45 per cent in 1992 (Figure 2.3).

Further analysis shows that while similar proportions of male and female nurses agreed with the statement (67 per cent and 63 per cent respectively), almost two-fifths (38 per cent) of male nurses agreed strongly, compared with 29 per cent of female nurses.

Despite this difference by gender (and the disproportionate representation of men in the higher clinical grades), the proportion of NHS nurses who agree with the statement is inversely related to their clinical grade. For example, 70 per cent of D grade nurses agreed, or agreed strongly, compared with 44 per cent of H grades.

Figure 2 : 3 'I could be paid more for less effort if I left nursing' — NHS nurses (1992 to 1996)



Source: IES 1996

Nurses working full time were also more likely to agree (66 per cent) than those working part time (58 per cent).

NHS nurses' perception that their relative earnings have declined, is shared by most nurses outside the NHS. Sixty-two per cent of non-NHS nurses and 53 per cent of GP practice nurses agreed with the statement.

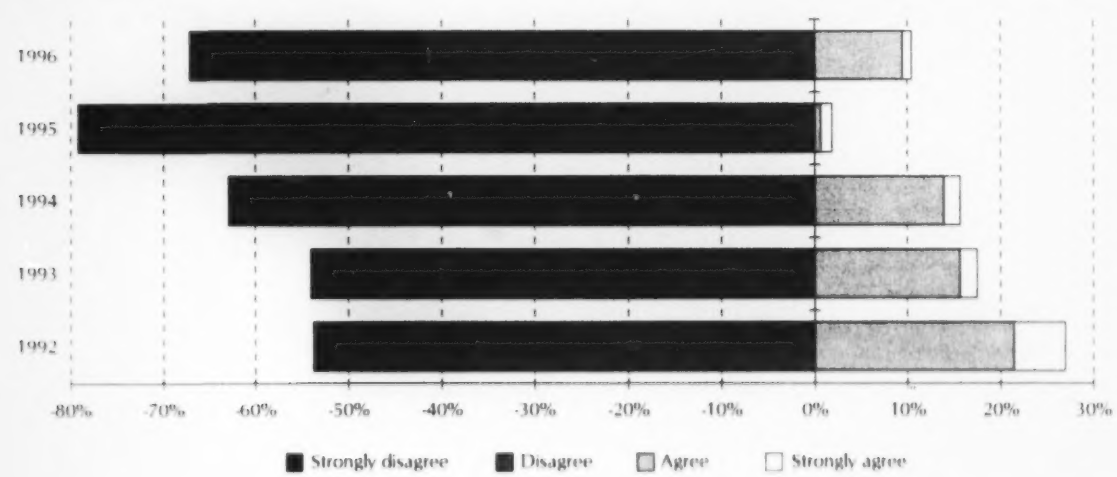
Turning to our second statement, *'considering the work I do I am well paid'*, we find that just over two-thirds (67 per cent) of NHS nurses rejected this view. This compares with little over half (52 per cent) of those in non-NHS nursing. In contrast, only a minority (33 per cent) of GP practice nurses and 35 per cent of those in nurse education, disagreed.

Figure 2.4 shows how the proportion of NHS nurses responding positively to this item has declined over time. The more extreme values in the 1995 survey probably reflect the fact that last year's survey was conducted against the background of the pay dispute (see Seccombe and Patch, 1995). Additionally, the 1996 survey was conducted close to implementation of the 1996 pay rise and the two per cent uprating.

Again, the proportion of positive responses increases with clinical grade (see Table 2.1 overleaf), despite the higher proportion of male nurses (33 per cent compared with 25 per cent of female nurses) who strongly disagreed with the notion.

The third statement *'NHS nurses are poorly paid in relation to other professional groups'* was introduced to the survey for the first time in 1995, when 83 per cent agreed, and 58 per cent agreed strongly. In 1996 we find that the proportion agreeing has increased to 87 per cent. Sixty-one per cent of male NHS nurses and 52 per cent of female NHS nurses agreed strongly with this item.

Figure 2 : 4 'Considering the work I do I am well paid' — NHS nurses (1992 to 1996)



Source: IES 1996

Table 2 : 1 'Considering the work I do I am well paid' — NHS nurses by clinical grade

	% who:				
Grade	Strongly Agree	Agree	Disagree	Strongly Disagree	Base No.
C	–	–	54	17	*46*
D	<1	5	42	33	*662*
E	1	9	43	26	*1,047*
F	1	11	38	24	*369*
G	1	13	40	19	*531*
H	1	18	44	11	*105*

Source: IES 1996

2.2.2 Local pay

In its Thirteenth report the Review Body comments that:

> *'It has become clear to us . . . that in general little or no attempt has been made to communicate the benefits of local pay determination to nursing staff, who tend to regard it largely as a cost-cutting exercise. This seems likely to have exacerbated staff fears about the inspiration for, and likely consequences of, local pay.' (para. 27)*

They comment further that:

> *'We believe that Trusts should set out to allay the fears of staff that local pay will lead to lower levels of pay and conditions. The perception that staff could only lose out through local pay determination was a striking feature of our visits.' (para. 28)*

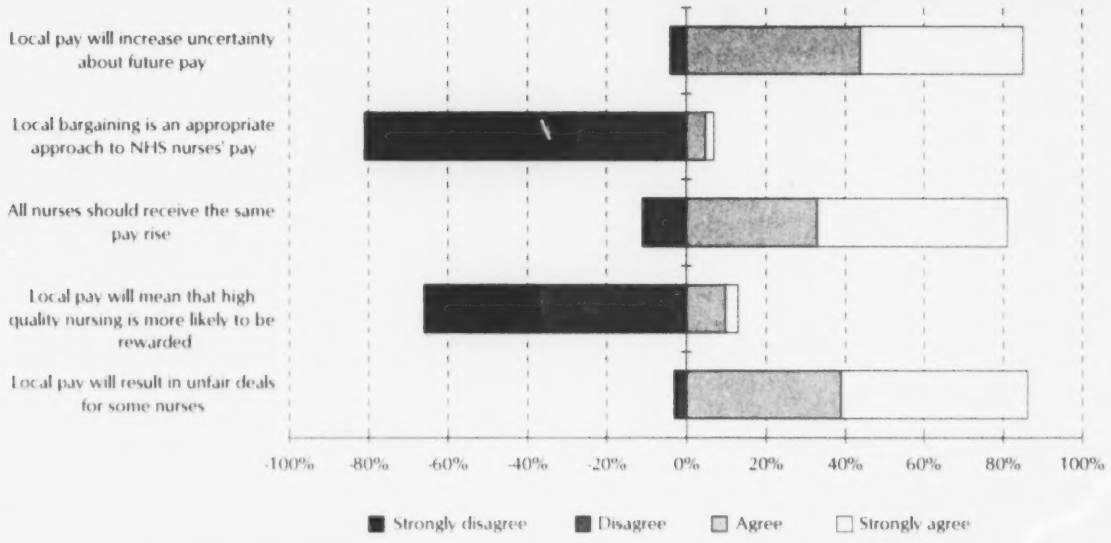
In this section we examine the extent to which nurses' concerns about the principle and practice of local pay have been allayed by management.

In 1995 we asked nurses to respond to a series of statements concerned with the principle of local pay determination. These items were:

- *local pay will increase uncertainty about future pay*
- *local pay bargaining is an appropriate approach to NHS nurses' pay*
- *all nurses should receive the same pay rise*
- *local pay will mean that high quality nursing is more likely to be rewarded*
- *local pay will result in unfair deals for some nurses.*

At the time of the 1995 survey, most nurses had not actually experienced either the process of local pay negotiation nor its outcome. One year later, we asked nurses to respond to the same statements. This section examines their responses and compares

Figure 2 : 5 Summary of local pay items — NHS nurses, 1996



Source: IES 1996

them with the 1995 survey. The overall responses for NHS nurses are summarised in Figure 2.5.

As in 1995, the overwhelming majority (85 per cent) of NHS nurses agree with the statement *'local pay will increase uncertainty about future pay'*. Local bargaining is rejected as *'an appropriate approach to NHS nurses' pay'*; as in 1995, only seven per cent of NHS nurses agreed with this statement. Nurses are unchanged in their view that local pay will not *'reward high quality nursing'*: only 13 per cent agree with this view.

Again, we find that the majority of respondents agree that *'all nurses should receive the same pay rise'*; in fact this proportion has increased marginally. Similarly, 86 per cent agree that *'local pay will result in unfair deals for some nurses'*, with nearly half (47 per cent) agreeing strongly.

The responses of nurses to these statements are unequivocal. The overwhelming majority of nurses remain unconvinced by the arguments put forward in favour of local pay determination; in 1995 they showed a pronounced lack of enthusiasm for the principle of local pay; in 1996 they also reject it from experience. The survey suggests that managers have so far failed to allay the fears alluded to by the Review Body.

2.2.3 Incremental pay

In the penultimate section of this chapter we turn to the third element of NHS nurses' pay; incremental growth within scales.

While Review Body pay awards have been comparatively low, and variable, in recent years, the annual incremental rise, for

Table 2 : 2 Review Body recommendations and outcomes (E grade) 1989 to 1996

	Review Body recommendation	Increase on mid-point of E grade	Incremental growth (point 3 to point 4) in E grade
1989	6.8%	£660	£400
1990	9.6%	£945	£435
1991	9.7%	£1,090	£475
1992	5.8%	£730	£500
1993	1.5%[1]	£200	£505
1994	3.0%	£400	£520
1995	1.5% to 3%[2]	£140	£525
1996	2% plus local	£560[3]	£545

1 Rate imposed by Government not by Review Body recommendation

2 1% increase in national scales plus local negotiations expected to produce a total between 1.5% and 3%

3 Includes 2% up-rating in national scales to reflect bulk of actual settlements at 3% in 1995

Source: IES 1996/Review Body reports

eligible NHS staff, has provided a more predictable source of increased salary.

In 1995/96 the latter ranged from £400 to £440 for a D grade nurse, around 3.3 per cent of the national salary scale, and between £450 and £665 for a grade E staff nurse (3.3 per cent and 4.4 per cent of the national salary scale). In some years the annual increment has been the main source of pay increase for many nurses (see Table 2.2 above).

However, as Table 2.3 shows, a high proportion of NHS nurses are now employed on the top increment of their scale and therefore do not receive any additional incremental increases. Overall, just under two-thirds (64 per cent) of NHS nurses were on the top increment, relying therefore on the Review Body recommendation and local negotiation for their pay increase.

Table 2 : 3 Proportion of NHS nurses on top increment of scale, by clinical grade

Grade	% on top increment	Base no.
C	89%	45
D	57%	647
E	65%	1027
F	54%	364
G	73%	524
H	66%	103
I	71%	21

Source: IES 1996

Table 2 : 4 Proportion of NHS nurses on top increment of scale by job title

Job title	% on top increment	Base no.
Sister/Charge nurse	66%	480
Enrolled nurse	88%	281
District nurse	70%	181
Clinical nurse specialist	61%	109
Staff nurse	57%	1,400
Health visitor	68%	60
Community psychiatric nurse	66%	47

Source: IES 1996

In each of the grades, a majority of staff are on the top increment. However, this proportion ranges from 54 per cent among F grades to 89 per cent of C grades.

Table 2.4 presents this data by job title. It shows that 88 per cent of enrolled nurses, 70 per cent of district nurses and 68 per cent of health visitors are on the top increments. These figures compare with 57 per cent of staff nurses, now the main entry point to the clinical nursing scales.

These proportions are likely to further increase in the short term for three main reasons. These are:

- the ageing of the nursing workforce — the survey data demonstrate that within six years of first registering, a majority of nurses are on the top increment
- the inflow of newly registered staff to the bottom of the scales will continue to decline because of recent past reductions in intakes to pre-registration nursing courses
- the lack of promotion prospects and vacancies in promoted posts — the survey indicates that only one in twenty NHS nurses was promoted to a higher clinical grade in the last twelve months.

Additionally, increasing numbers of NHS nurses may be offered employment on trust contracts in posts which have no incremental salary progression, or where such progression is dependent on performance appraisal.

The effect of being on the top increment with little prospect of further progress ensures that the Review Body award and local determination assume even greater prominence for many nurses. On each of the local pay items presented above, further analysis shows that nurses on the top increment of their clinical grade were marginally more likely to reject local pay than their colleagues. This may help to explain, in part, the strength of nurses' opposition to local pay.

2.2.4 Pay in non-NHS nursing

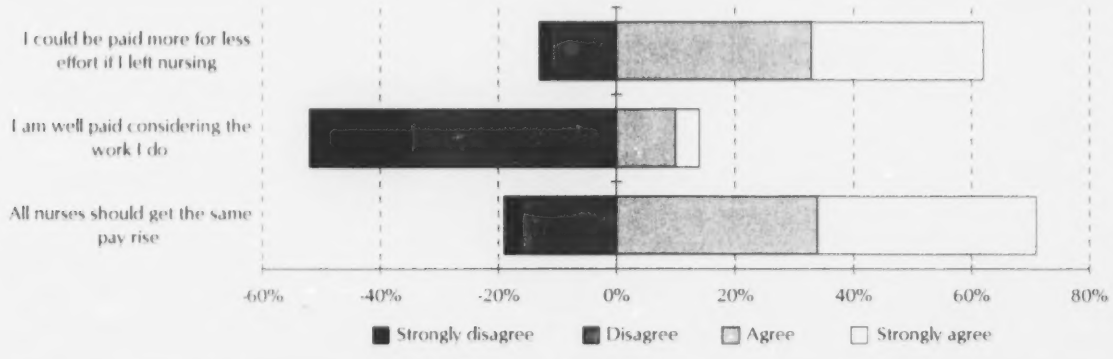
The survey respondents include a little over 500 non-NHS nurses. These include nurses in independent hospitals, nursing and residential care homes, hospices, prisons, military, industry and commerce. In general, employers in these sectors followed Whitley and the Review Body recommendations in setting their pay rates to roughly parallel national scales. In 1995 they were able to continue this strategy, since the majority of settlements coalesced around three per cent. However, the fact that the 1996 Review Body report makes no recommendation on the size of any local pay element, means that some employers (for example the Prison Service) are having to put new negotiating processes in place. Others, particularly in the nursing homes sector, may have little scope for pay flexibility, if they are dependent on income from DSS funded residents.

Given this past pay strategy, it is not surprising to find that the pattern of responses given by non-NHS nurses to the pay satisfaction statements, broadly echo those of NHS nurses. These are summarised on Figure 2.6.

Sixty two per cent of non-NHS nurses agreed that *'I could be paid more for less effort if I left nursing'* (compared with 63 per cent of NHS nurses). A fifth (22 per cent) of these nurses felt that they were *'well paid considering the work I do'* (compared with 11 per cent of NHS nurses). The majority (71 per cent) also agreed that *'all nurses should get the same pay rise'* (compared with 81 per cent of NHS nurses).

Comparison between the two main groups of respondents within non-NHS nursing (those in independent acute hospitals and those in nursing homes) reveals little difference. A higher proportion (67 per cent) of nurses in independent acute hospitals agreed that they could be paid more for less effort if they left nursing, compared with 60 per cent of those in nursing homes. Paradoxically, independent acute hospital nurses were also more likely to agree that they were *'well paid considering the work I do'*.

Figure 2 : 6 Summary of pay satisfaction items — non-NHS nurses



Source: IES 1996

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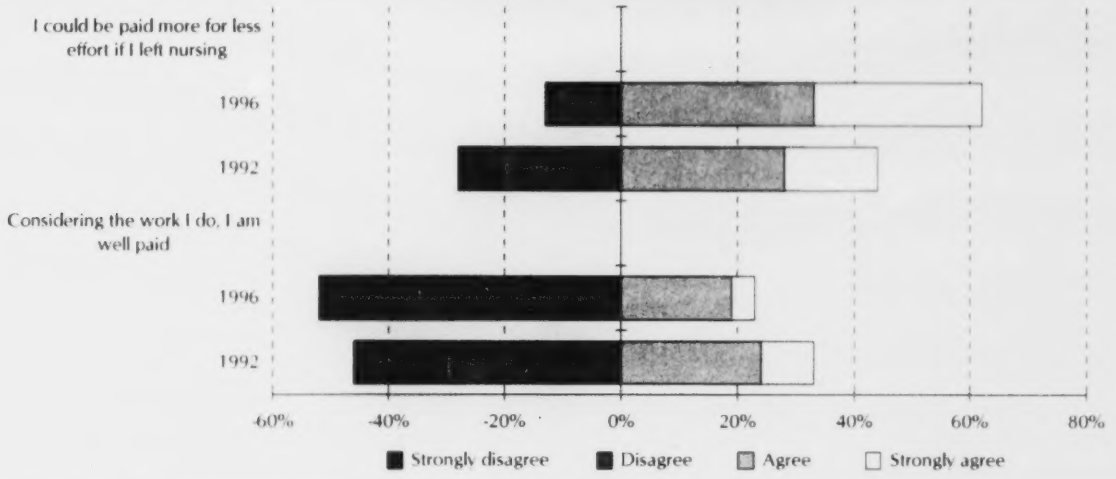
Figure 2 : 7 Non-NHS nurses — pay satisfaction scores 1992 and 1996



Source: IES 1996

Almost a quarter (24 per cent) agreed or agreed strongly with this statement, compared with 17 per cent of nurses in nursing homes. Three-quarters of the latter agreed that *'All nurses should receive the same pay rise'* compared with 64 per cent of those in independent acute hospitals. Independent evidence shows that, in general, pay in independent hospitals is higher than in nursing homes[1].

Analysis of non-NHS nurses' responses over time shows a marked deterioration in pay satisfaction, similar to that of NHS nurses. Figure 2.7 (above) shows that the proportion who agreed with the statement *'I could be paid more for less effort if I left nursing'* has risen from 44 per cent in 1992 to 62 per cent in 1996, while those who agreed that *'considering the work I do I am well paid'* dropped from a third in 1992 to less than a quarter in 1996.

2.3 Key findings

The key findings in this chapter include:

- Nurses' relative earnings have fluctuated in the 1990s, but have consistently been below average non-manual earnings, since 1991.
- Reflecting this, the survey evidence shows declining pay satisfaction over the same period; two-thirds of NHS nurses believe they could be paid more, for less effort, if they left nursing.

[1] IDS (August 1990), 'Hospital and nursing home pay', *Management Pay Review* No. 186, pp. 15

- **The proportion of NHS nurses agreeing that they are *'poorly paid in relation to other professional groups'* has also increased, to 87 per cent.**
- The vast majority of NHS nurses continue to regard local bargaining as an inappropriate approach to NHS nurses' pay, and to agree that local pay will result in unfair deals for some nurses.
- NHS nurses have not been convinced by the arguments put forward in favour of local pay; few believe that it will reward high quality nursing, even more agree that it will increase uncertainty.
- In recent years the annual incremental rise, for those eligible, has been the main source of pay increase.
- However, nearly two-thirds of NHS nurses (and 88 per cent of NHS enrolled nurses) are now on the top increment of their scale. These nurses rely on the outcomes of the Review Body recommendation and local negotiation for their pay increase.
- Non-NHS nurses' pay satisfaction levels and trends echo those of NHS nurses.

3. Turnover, Wastage and Retirement

3.1 Introduction

The annual IDS public sector labour market survey, conducted in the Autumn of 1995, reported evidence of a *'tightening labour market'* (IDS, 1995). Eighty-two per cent of NHS respondents reported recruitment and retention difficulties, and 40 per cent of these said that such problems had worsened in the year. The authors report that NHS trusts had cited three factors:

- shortfalls in the numbers being trained
- the spread of fixed-term contracts
- increased turnover.

This chapter deals with the third of these factors and reports the survey findings on nurse turnover and wastage.

Nurse retention and turnover were widely acknowledged as key concerns of personnel directors in the 1980s. To some extent the NHS benefited from the recession, in that high interest rates and mortgage costs and rising unemployment, or uncertain employment, among nurses' spouses/partners, contributed to the dampening down of turnover in NHS nursing.

However, there is growing evidence which suggests that this effect has now dissipated, that vacancy rates for some groups are rising and that retention is again a key issue for many trusts. High rates of turnover may destabilise work groups through the loss of experienced staff, may have an adverse effect on staff morale, and may ultimately undermine the volume, continuity and quality of patient care.

Turnover costs can also be a significant burden, in terms of the direct and indirect use of resources. Research by Seccombe and Buchan (1991) identified average turnover costs of £3,000 for an E grade staff nurse and significantly higher costs for experienced staff at ward sister level and above. Using assumptions of 25 per cent turnover and turnover costs of £3,000 per nurse, they estimate that a 350 bed hospital employing 700 nurses would incur turnover costs of £525,000 per annum, or 6.8 per cent of the paybill. A forthcoming Audit Commission report has recently validated the approach used and calculated average turnover

costs for the same benchmark (in 1995) of £4,900 (Audit Commission, 1996).

It is also important to recognise that there are benefits from a certain level of turnover. Most notably these benefits include: freeing up posts to allow new blood into the organisation, enabling career progression, providing opportunities for cost reduction.

Mapping and interpreting the level, characteristics, trends, and changing rationale for job changes within the nursing labour market, and flows into and out of this market, are important for several reasons. These include:

- turnover and wastage are key variables in determining the supply of registered nurses and in setting the number of nurse education places commissioned
- an increasing level of job change within a sector may be an early warning of supply side problems
- turnover intentions are widely regarded as a good general barometer of job satisfaction.

The measurement of staff flows is difficult in the NHS. In particular, the lack of reliable and consistent information on the turnover and wastage of the nursing workforce is a continuing problem. In its Ninth Report on Nursing Staff, Midwives and Health Visitors (1992), the Review Body commented: *'We ... regret that reliable information on wastage from the NHS is not available'* (para. 42). Since then the available data set has probably deteriorated rather than improved.

In this report, as in previous years, we distinguish between turnover and wastage. Many reports use the term 'wastage' to mean all leavers. Here it is used only to refer to those leaving an employment sector (*eg* NHS nursing). The term 'turnover' is used to refer to the totality of leavers — which includes those moving within a sector (*eg* from one NHS trust to another), those moving between sectors (*eg* from NHS to non-NHS nursing) and those leaving paid employment altogether (*eg* to retirement). These distinctions are important for workforce planning purposes.

It is important to have reliable data on both turnover and wastage, since the effectiveness of policies on recruitment, retention and the likelihood of return depend, in part, on knowing where leavers are going. The likelihood of a leaver returning is related to whether they leave the local labour market, whether they leave to raise a family, or move to another NHS post. A recent OPCS survey (Lader, 1995) shows that almost two-thirds of those who were out-of-service at the time of the census had returned to the profession as a registered nurse within two years, a further 20 per cent having returned to more senior posts.

For the NHS in England, there were, until recently, limited data available centrally from the KM48 return. KM48 recorded information about numbers and whole-time equivalents of non-medical staff joining and leaving NHS organisations. However, there were a number of important exclusions from KM48 (*eg* staff whose employment is of a casual or temporary nature) and it was widely regarded as inaccurate, incomplete and unreliable. In April 1996, KM 48 was discontinued by the NHS Executive.

Data on nurse turnover and wastage are now collected via two main processes. These are:

- data provided by individual trusts as part of the annual National Balance Sheet exercise
- data collected by the OME as part of the NAPRB Manpower Survey (a revision of NURVAC) introduced for the first time in 1996.

It remains to be seen whether these sources will provide the robust data required for planning purposes.

The annual IES/RCN survey is an imperfect method of collecting turnover and wastage data. In particular, because of the sample composition, it has a tendency to underestimate wastage rates. Nevertheless, it has the merits of detail and consistency in definition which other sources lack. Moreover, there are robust trend data for the last eight years.

The chapter is structured as follows:

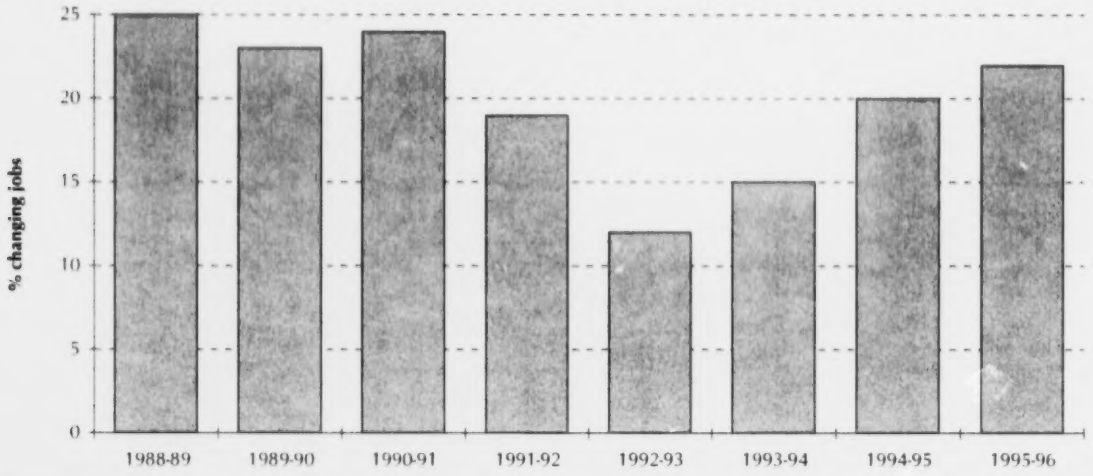
- the extent to which nurses are changing jobs within the NHS (section 3.2.1)
- the employment and other destinations of those who left NHS nursing (section 3.2.2)
- the reasons given by NHS nurses for job changes (section 3.2.3)
- retirement, early retirement and ill-health retirement (section 3.2.4)
- turnover and wastage in non-NHS nursing (section 3.2.5)
- future turnover intentions (section 3.2.6)
- the relationship between turnover and morale (section 3.2.7).

3.2 Results

3.2.1 Turnover in NHS nursing

Headline turnover has risen for the third year in a row. We find that 22 per cent of respondents who were in NHS nursing posts a year ago, changed jobs or stopped working during 1995 to

Figure 3 : 1 Turnover among NHS nurses, 1988 to 1996



Source: IES 1996

1996. This compares with a figure of 20 per cent during 1994 to 1995 and 15 per cent during 1993 to 1994.

Figure 3.1 shows the trend in NHS nurse turnover as recorded by the IES/RCN surveys since the late 1980s.

This headline turnover figure includes moves within the NHS as well as between the NHS and other employment sectors, and those leaving paid employment altogether.[1] This is a minimum figure, since an unknown proportion of those changing jobs and of those leaving nursing are also likely to leave RCN membership and so be excluded from the sample. Additionally, the sample excluded those who were known to be retired at the time of sampling.

Inevitably, most of this turnover is accounted for by nurses moving between different posts within the NHS (see Table 3.1 overleaf). The majority (78 per cent) of NHS nurses who changed jobs remained in the NHS, with 73 per cent staying in NHS nursing and one per cent going into NHS management posts. The figure includes those NHS nurses on statutory maternity leave, although in practice not all will return to NHS nursing. It is slightly lower than the 1995 figure (79 per cent), reflecting an increase in 'wastage' from the NHS (see below) and the fact that moves into nurse education are now recorded as non-NHS destinations.

More than a third (37 per cent) of the NHS nurses who moved to new posts in the year also changed employer. The comparable figure for 1995 was 27 per cent. An increase in the proportion of

[1] The turnover figure excludes those who were students one year ago and who started work as qualified nurses in the NHS during 1995 to 1996.

Table 3 : 1 Current employment of NHS nurses who changed jobs during 1995 to 1996

Current employment	%
Moves within the NHS:	**78**
in NHS nursing	73
to NHS management	1
to statutory maternity leave	4
Moves from the NHS to:	**22**
Non-NHS nursing	5
Retired	4
Bank nursing	3
Career break	2
Non-nursing jobs	1
Agency nursing	1
Nurse education	1
GP practice nursing	1
Unemployed but seeking work	>1
Other /imprecise	2
Base number = 497	

Source: IES 1996

job changes which involves moves between NHS trusts, rather than changes within trusts, suggests that there is a growth in labour market 'churning', particularly since comparatively few of these job moves seem to be accompanied by grade changes.

An increasingly volatile labour market may reflect growing demand for registered nurses from a combination of factors including: increased wastage (*eg* due to an increase in retirements or flows to non-NHS employment), a growth in the demand for high quality nursing inputs, and shortfalls in supply (returners or newly registered). The evidence from this survey and other independent sources suggests that all three factors may be converging[1].

Again, the survey shows a high rate of job change by newly qualified nurses. Half of those who first registered in the last three years changed jobs in the last 12 months. Excluding those who were previously learners, this indicates a turnover figure of 35 per cent among the recently qualified.

Table 3.2 (overleaf) shows the reasons stated by NHS nurses for moving between NHS jobs. Positive reasons, including promotion and the desire to develop new skills, account for 40 per cent of these moves. Other, less positive, causes account for nearly a third of moves. These include: dissatisfaction (16 per cent), ill-

[1] Buchan J (1996) 'Nursing shortages', *British Medical Journal*, Vol. 312, 20 January, pp. 134-5

Table 3 : 2 NHS nurses: reasons for changing jobs within the NHS, during 1995 to 1996

Reason	%
Promotion	25
Dissatisfaction	16
To develop new skills	15
Ill-health/injury	7
Moved from area	5
Further training/additional qualification	5
Unit/ward closure and redundancy	5
Change of working hours	3
End of temporary contract	2
Secondment	1
Other	16
Base number = 362	

Source: IES 1996

health and injury (seven per cent), unit or ward closure (five per cent) and end of temporary contract (two per cent).

Other reasons given for job changes within the NHS include: post downgraded, to reduce travel time, and to change lifestyle.

3.2.2 Leaving NHS nursing

For the second year running, the survey shows an increase in wastage from NHS nursing. Just under six per cent of those who were in NHS nursing one year ago had left at the time of the survey. This compares with figures of five per cent during 1994 to 1995, four per cent during 1993 to 1994, and four per cent during 1992 to 1993. Again, this must be regarded as a minimum figure, as the sample may be biased against such leavers since they may leave RCN membership when they leave nursing.

Of those NHS nurses who left NHS nursing, half remained in direct care nursing jobs, including agency and bank nursing (19 per cent), GP practice nursing jobs (six per cent) and independent sector nursing (25 per cent) (see Table 3.3 overleaf). The other main destinations were retirement (17 per cent) and career breaks (ten per cent). A proportion of the latter may return to the NHS at a later date.

These proportions are similar to 1995, with two notable exceptions:

- Firstly, the proportion of the NHS leavers who retired or left on ill-health grounds during 1994 to 1995 was ten per cent; during 1995 to 1996 this has doubled to 20 per cent (for further discussion see section 3.2.4).

Table 3 : 3 Current employment status of those leaving the NHS during 1995 to 1996

Destination	%
Non-NHS nursing	25
Bank/agency nursing	19
Retirement	17
Career breaks	10
GP practice nursing	6
Non-nursing work	6
Further/higher education	6
Unemployed	3
Long-term sick leave	3
Other	5
Base number = 104	

Source: IES 1996

- Secondly, the proportion leaving to take up posts as GP practice nurses has fallen from ten per cent in 1994-95 to six per cent in 1995-96.

These two trends are based on comparatively small numbers of respondents and should therefore be interpreted cautiously.

3.2.3 Reasons for leaving the NHS

Respondents who had changed jobs or stopped working in the last year, were asked for their main reason for this change. The responses of those who left NHS nursing (excluding those on statutory maternity leave) are given in Table 3.4 (overleaf).

Nearly a quarter (23 per cent) of these leavers indicated that job dissatisfaction was their main reason for leaving, with 18 per cent reporting ill health or injury, 12 per cent wanting to develop new skills, and 11 per cent retiring.

Looking more closely at those who cited 'job dissatisfaction' as their reason for leaving the NHS, we find two interesting patterns.

- Firstly, the majority (71 per cent) are now in nursing jobs outside the NHS. This compares with half of all NHS nursing leavers. This suggests that it is not nursing itself which these nurses were dissatisfied with.
- Secondly, more than a third (37 per cent) of these leavers had first registered since 1990, compared with 17 per cent of all NHS nursing leavers.

3.2.4 Retirement, early retirement and ill-health

The number of people taking early retirement from the NHS doubled in the early 1990s according to official data. Excluding

Table 3 : 4 NHS nurses: reasons for leaving the NHS, during 1995 to 1996

Reason for leaving	%
Dissatisfaction with job	23
Ill-health/injury	15
Retired	11
To develop new skills	10
Promotion	7
Moved from area	7
Redundant	3
End of temporary contract	2
Gained further qualification	2
Downgraded	1
Other	19
Base number = 127	

Source: IES 1996

those who left as a result of ill-health, the number of staff retiring at age 50 or over grew from 3,108 during 1991 to 1992, to 6,318 during 1993 to 1994. The number taking ill-health retirement has also increased in each of the last three years, from 7,387 during 1991 to 1992, to 8,613 during 1993 to 1994[1]. Separate figures are not available for nurses, but simple inspection of the changing age profile (Figure 3.2 overleaf) suggests that retirement will be an increasingly significant source of loss from the workforce.

Analysis of NHS nurses' age profile suggests that the numbers of nurses retiring is likely to increase substantially over the next few years, as the bulge of 45 to 49 year olds begin to come within the scope of early and normal retirement ages. Opportunities for retirement (on reduced pensions) are now available for all over the age of 50. As a result, a quarter of survey respondents currently in NHS nursing will be eligible to retire by the millennium.

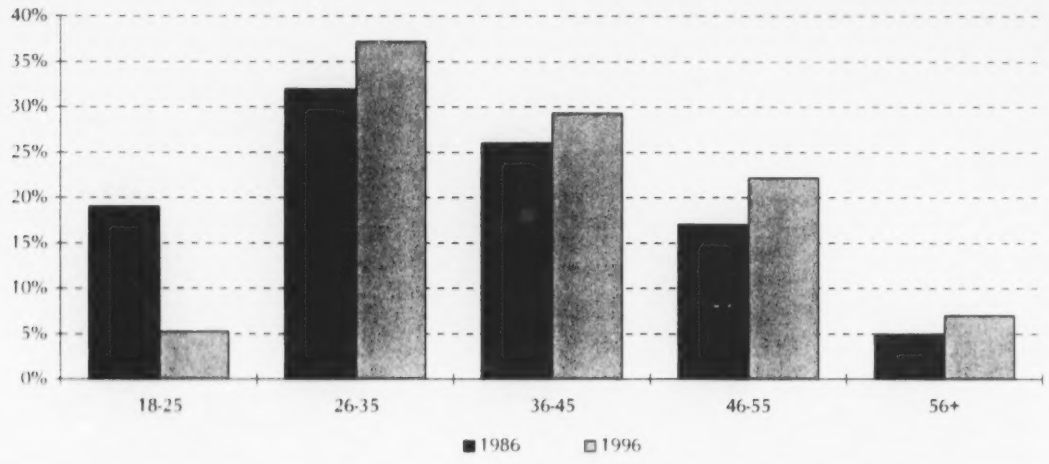
One in five (21 per cent) of the female NHS nurses who responded to the survey are aged between 45 and 54, with a further five per cent already working beyond the normal retirement age. Around two per cent of male nurses are aged 60 or over.

Overall, some three per cent of the survey respondents retired in the year. This is likely to under-estimate the true level of retirement from nursing because of the sampling method.[2] Nevertheless, normal and early retirement still accounted for 11

[1] Hansard (HC), 18 July 1994, cols. 13-14.

[2] The sample is of those paying the full RCN membership fee; since those in retirement are entitled to a discounted membership fee, it is likely that only very recently retired members, or those who retired on ill-health grounds are included in the sample.

Figure 3 : 2 Age profiles 1986 and 1996 (NHS nurses)



Source: IES Surveys, 1986 and 1996

per cent of those leaving NHS nursing. This proportion has increased from seven per cent of those leaving NHS nursing during 1994 to 1995.

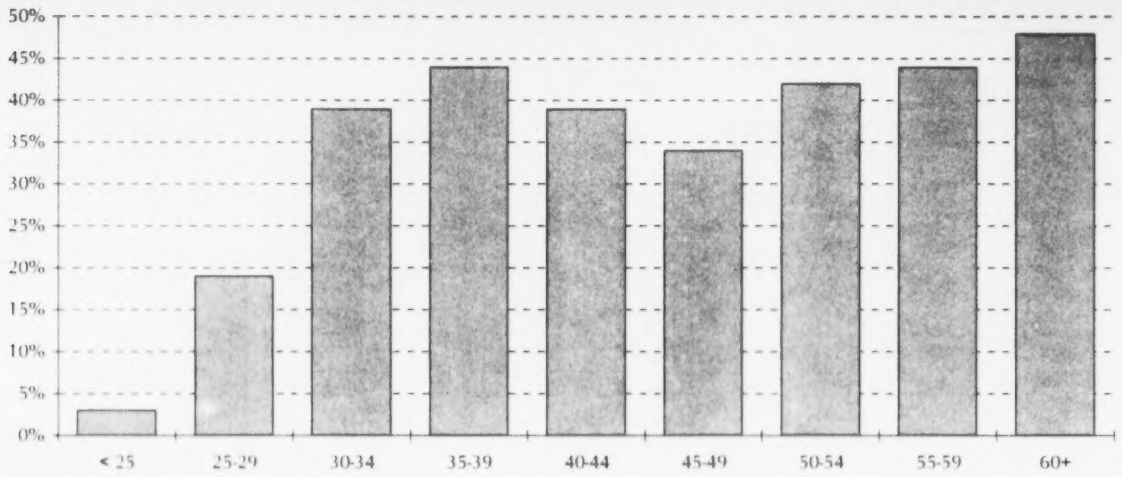
Excluding those who retired early on ill-health grounds, more than two-thirds of retirements were before age 55, with 47 per cent between ages 45 and 54. Normal retirement for most members of the NHS Pension Scheme is at age 60. Members of the special classes (including those nurses, midwives, occupational health nurses and health visitors who joined the Scheme before 6 March 1995) have special retirement rights enabling them to retire with benefits from the age of 55. Members of the Scheme may also choose to take voluntary early retirement, with reduced benefits, at or after age 50[1].

The survey asked about nurses' retirement intentions. Overall, three per cent of NHS nurses indicated that they expected to retire in the next two years. This proportion rises from seven per cent of those aged 50 to 54, to 35 per cent of those 55 to 59, and 58 per cent of those aged 60 and over. These figures are almost exactly the same as in 1995.

The survey evidence also suggests that early retirement is only one option available to older nurses. Others may choose to continue working in nursing but reducing their hours, for example by working on a nursing bank or agency, or by working part time. Figure 3.3 (overleaf) shows the proportion of NHS nurses working less than full time, by age group. This pattern appears broadly to reflect life cycle stages. The proportion of nurses working part time increases with age, to peak at 44 per cent among those aged 35 to 39 (the age group with the highest

[1] NHS Pensions Agency, *A guide to the NHS Pension Scheme*, March 1995.

Figure 3 : 3 NHS nurses working part time, by age group



Source: IES 1996

proportion of dependent children). Part-time working then reduces among those aged 40 to 49, before rising steadily to almost half of those aged 60 and over.

These findings may suggest that the concept of 'downshifting', where people seek a less complicated working life later in their careers, may also be loosening employers' hold on older nurses. These more subtle changes in the supply of registered nurses need to be given consideration in exercises to forecast future nurse numbers.

Ill health and injury are also significant factors in both turnover and wastage. Seven per cent of the job changes within NHS nursing were reported to be a result of ill-health or injury, while three per cent of those who left NHS nursing were currently on long-term sick leave. Overall, almost one in five (18 per cent) of those who left NHS nursing cited ill-health or injury as the main reason and only ten per cent of these leavers were currently in any form of paid employment.

3.2.5 Turnover in non-NHS nursing

Turnover and wastage from the non-NHS nursing sector are an important component of change in the supply of nurses to the NHS, since a high proportion of NHS leavers go to non-NHS nursing jobs. As we saw above, a quarter of those leaving the NHS went to non-NHS nursing jobs (excluding bank, agency and GP practice nursing). Clearly, growth and turnover in this sector have a knock-on effect on the supply of nurses to the NHS. Equally however, non-NHS nursing is a potential source of recruits into NHS nursing.

In the non-NHS nursing sector we find a similar level of overall job change, with one in five respondents changing jobs, or

Table 3 : 5 Current employment of non-NHS nurses who changed jobs during 1995 to 1996

Current employment	%
Another non-NHS nursing job	47
NHS nursing	21
Bank nursing	8
Agency nursing	2
GP practice nursing	2
Statutory maternity leave	4
Career break	4
Non-nursing employment	4
Nurse education	1
Other	7
Base number =102	

Source: IES 1996

stopping paid work altogether during the last year. Almost half (47 per cent) of this turnover is accounted for by moves between non-NHS employers. This suggests a comparatively lower (nine per cent) level of turnover within the sector than within NHS nursing.

Table 3.5 shows the current employment of those who were in non-NHS nursing one year ago, and who changed jobs or stopped working.

NHS nursing was the main destination for leavers, accounting for 21 per cent of all job changes. That is, a little under five per cent of those in non-NHS nursing one year ago moved to NHS nursing jobs. Despite this, the NHS was a net loser; the number of nurses moving from NHS to non-NHS nursing employment was more than double the number who moved from non-NHS nursing to NHS nursing employment. The other main destination of those who remained in nursing employment was bank and agency work (ten per cent).

Table 3.6 (overleaf) shows the main reasons given by these respondents for their job change. Job dissatisfaction was cited by more than two-fifths (41 per cent), followed by 'moved away from the area (13 per cent), and to develop new skills (12 per cent).

Turning finally to those nurses in GP practice employment, we find that turnover was lower than in the other sectors. Only eight per cent of those who were in GP practice nursing one year ago reported changing jobs or stopping work altogether in the last twelve months. More than two-fifths of this turnover is accounted for by statutory maternity leave (28 per cent), career breaks (eight per cent), and retirement (eight per cent). Just over a quarter (28 per cent) of job changes involved moves to NHS nursing. There appears to be comparatively little movement of

Table 3 : 6 Non-NHS nurses: reasons for changing jobs during 1995 to 1996

Reason	%
Job dissatisfaction	41
Moved from area	13
To develop new skills	12
Promotion	11
To change working hours	4
Ill-health or injury	3
Redundancy	3
End of temporary contract	1
Other	12
Base number = 79	

Source: IES 1996

GP practice nurses between practices; less than four per cent reported having changed employer within the sector. Note that this analysis is based on a small number of cases.

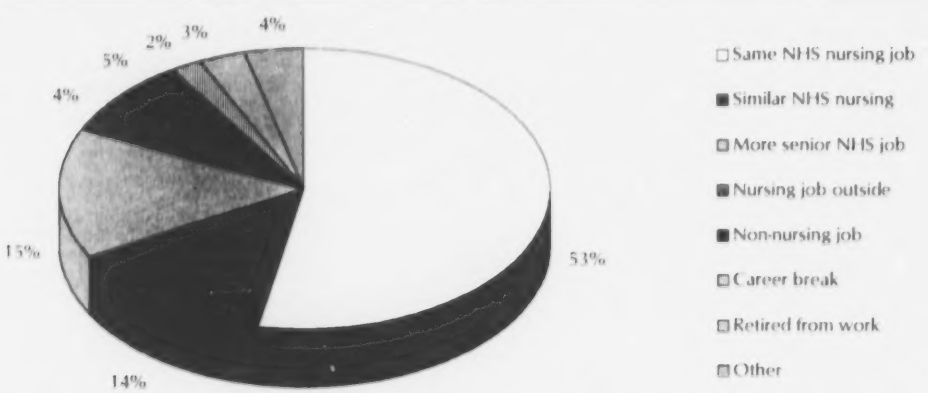
3.2.6 Future turnover

One of the key determinants of the future supply of nurses to the NHS is the likely level of future wastage from the NHS to other forms of employment. The evidence presented earlier shows that both turnover and wastage are increasing.

In this section we present survey evidence on the turnover and leaving intentions of NHS nurses and their perceptions of the desirability of leaving nursing.

Nurses were asked to indicate what they thought they would be doing in two years' time. The responses of NHS nurses are shown on Figure 3.4.

Figure 3 : 4 NHS nurses' anticipated employment in 1998



Source: IES 1996

Table 3 : 7 Proportion of nurses who expect to have left the NHS by 1998, by job title

Job title	% not in NHS nursing in two years	Base no.
Senior nurse manager	30	40
Ward sister	17	491
Enrolled nurse	13	285
District nurse	10	191
Clinical nurse specialist	14	116
Staff nurse	20	1,447
Health visitor	17	60
Community psychiatric nurse	7	46

Source: IES 1996

Around half (53 per cent) expected to be in the same NHS job with one in seven (14 per cent) saying that they expected to be in a similar job but in a different NHS trust. Only 15 per cent thought that they would be in a more senior NHS job, compared with 19 per cent in the 1995 survey.

Nearly one in five (18 per cent) respondents expects to leave the NHS within two years. This is a similar figure to last year's survey finding (20 per cent expected to have left) and double the 1988 figure. Among those who expect to leave NHS nursing, four per cent expected to be in a non-NHS nursing job and five per cent in a non-nursing job. Most of the remainder anticipated retirement (three per cent), taking a career break (two per cent), further education or working abroad[1].

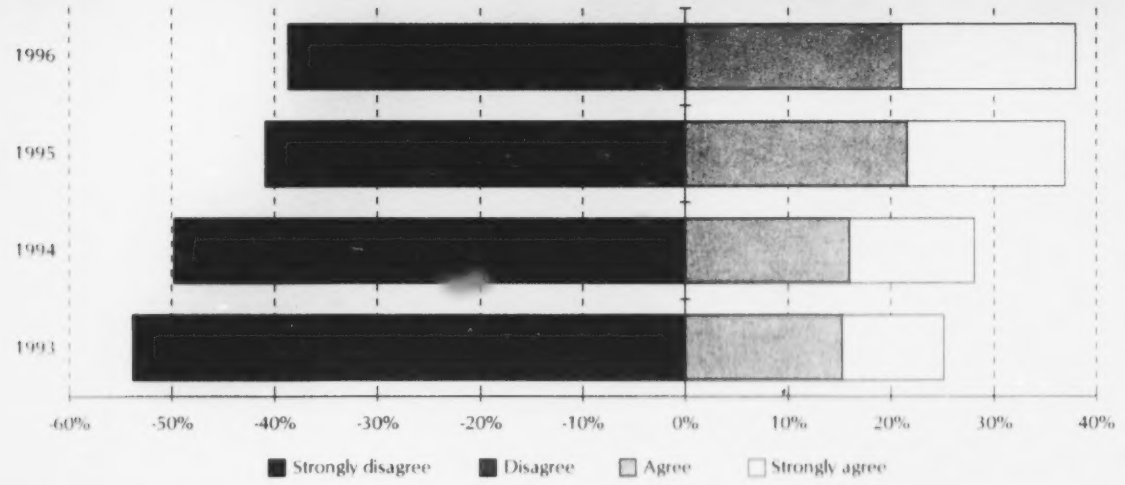
Over half (52 per cent) of those who expect to leave NHS nursing, are aged under 35. Put another way, a fifth of NHS nurses aged under 35 expect to leave in the next two years.

Table 3.7 (above) shows that the proportion of NHS nurses who expect to leave NHS nursing within two years varies by job title. This ranges from a peak of 30 per cent among senior nurse managers to seven per cent for community psychiatric nurses.

Turning to those respondents currently in non-NHS nursing, we find that three-quarters expect to be in the same, or a similar, non-NHS nursing job in two years' time. This compares with two-thirds of NHS nurses. Among the remainder, six per cent expect to be in an NHS nursing job, with seven per cent in non-nursing jobs, five per cent retired, and two per cent taking career breaks.

[1] Note that the IES and the RCN have set up a survey panel from amongst the 1996 respondents; we will therefore be able to compare actual and forecast job moves by these nurses when they are re-surveyed in 1998.

Figure 3 : 5 'I would leave nursing if I could' — NHS nurses (1993 to 1996)



Source: IES 1996

3.2.7 Turnover and morale

Turnover intention has frequently been cited as a good indicator of morale in organisations. In particular, low levels of job satisfaction have been shown to influence stated intention to leave. One way of gauging the extent to which nurses perceive leaving the profession as desirable or not, is to examine the extent to which they agree or disagree with the statement *'I would leave nursing if I could'*.

Figure 3.5 (above) compares the responses of NHS nurses in 1996 with those of the previous four surveys.

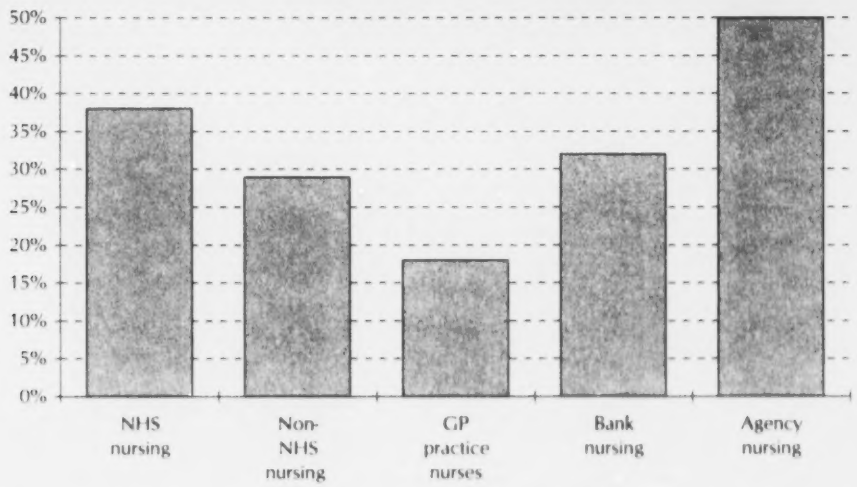
In 1993, a quarter of NHS respondents agreed or agreed strongly with the statement. This proportion has increased in each of the subsequent surveys, reaching nearly two-fifths (38 per cent) in 1996. Further, the proportion who agreed strongly has grown from just under ten per cent in 1993 to 15 per cent in 1995 and 17 per cent in 1996.

Further analysis shows that turnover intentions, using this measure, are higher among acute hospital (40 per cent) based nurses, than among those in non-acute hospital (35 per cent) or community settings (32 per cent).

Figure 3.6 (overleaf) shows that NHS nurses are substantially more likely to agree with the statement than GP practice nurses and nurses in most other non-NHS nursing employment.

Responses to the statement resonate closely with nurses' employment expectations in two years' time. For example, only a quarter (26 per cent) of NHS nurses who expected to be in a more senior NHS nursing job in two years' time agreed or strongly agreed with the statement, and a third (35 per cent) of

Figure 3 : 6 Proportion who agreed 'I would leave nursing if I could', by current employment

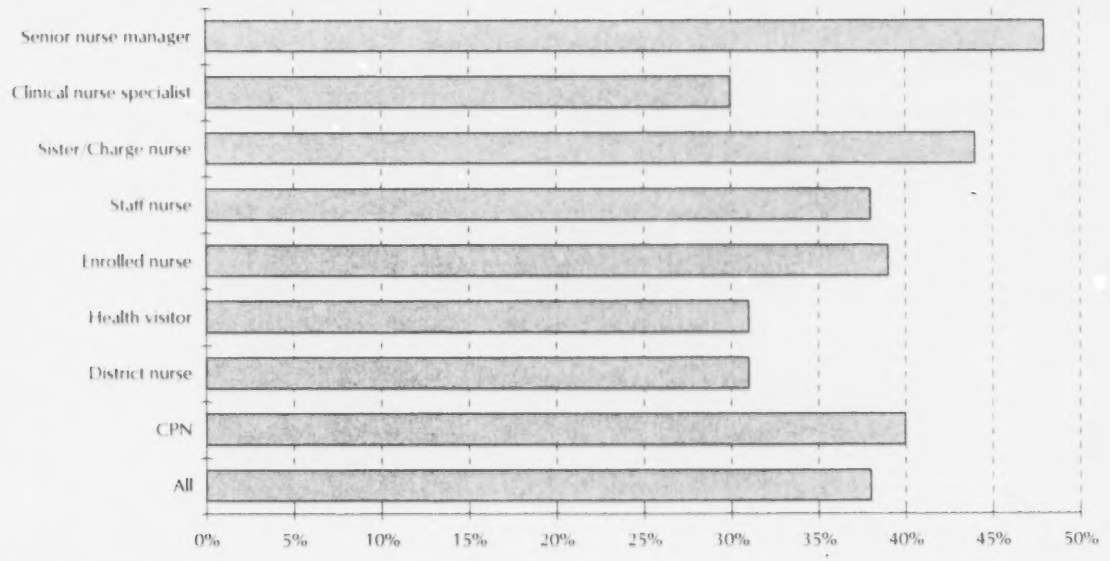


Source: IES 1996

those who expect to be in the same NHS nursing job. These figures compare, not surprisingly, with 87 per cent of those who expected to move to a non-nursing job, and with 63 per cent of those who expect to be in a non-NHS nursing job.

Figure 3.7 (below) shows that the proportion of NHS nurses who agreed or agreed strongly with the statement, varies by job title from just under half (48 per cent) of senior nurse managers to less than a third of clinical nurse specialists (30 per cent), health visitors (31 per cent) and district nurses (31 per cent).

Figure 3 : 7 Proportion of NHS nurses who 'would leave nursing if they could', by job title



Source: IES 1996

Overall, these data suggest that for a high proportion of nurses, particularly those in NHS nursing, there is a significant mismatch between the rewards (including management style, career prospects, working hours) offered by the work environment, and their needs and expectations. As a result, they tend to agree that they would leave nursing if they could. However, the extent to which they are able to do so is determined by external job opportunities and their own personal and domestic circumstances. Thus 38 per cent of NHS nurses agreed that they *'would leave nursing if they could'* but only 13 per cent actually expect to be in non-nursing employment or not in employment altogether, in two years' time.

3.3 Key findings

The key findings presented in this chapter include:

- Turnover in the NHS nursing has increased for a third year running; at least 22 per cent of NHS nurses changed jobs or stopped working in the last 12 months.
- The NHS nursing labour market is more volatile this year than last — 37 per cent of those NHS nurses who changed jobs also changed trusts.
- Job dissatisfaction, ill-health, injury and redundancy account for nearly a third of job changes within the NHS.
- Wastage from NHS nursing has also increased, to not less than six per cent.
- Twenty-eight per cent of NHS leavers said that job dissatisfaction was their main reason for leaving; most remained in nursing jobs.
- Retirement, early retirement and ill-health retirement account for an increasing proportion of leavers (more than one in ten).
- One in five NHS nurses expects to leave the service by 1998; few anticipate career progression within the NHS.
- Almost two-fifths of NHS nurses said that they would leave nursing if they could.
- Both turnover and wastage are comparatively lower in non-NHS nursing, and lowest among GP practice nurses.

4. Recruitment, Retention and Return

4.1 Introduction

The 1996 Review Body report drew attention to evidence of local difficulties in recruitment and retention and problems with particular specialties, stating that there were *' . . . signs that more general shortages may emerge in the future'* (para. 81). The Review Body also commented that factors such as *' . . . the design of individual jobs that take account of the needs of potential employees, and the procedures for facilitating the return to the workforce of qualified nursing staff, are also very important'* (para. 81).

The idea that there is a pool of registered nurses who are not currently in nursing employment, but who can be encouraged back into the profession with comparative ease at time of nursing shortage, has for a long time been the panacea for nursing shortages proposed by workforce planners. A Ministry of Health report from 1947 highlighted the potential for attracting 'married nurses' back to work as a solution to nursing shortages[1].

Contemporary analysis suggests that nurse participation rates have risen and, as a consequence, the pool of potential returners may be shrinking. An OPCS study conducted in the mid-1970s and based on data from the 1971 census, suggested a participation rate (in nursing) of 60 per cent for qualified nurses, and that two-thirds of those not currently employed in nursing intended to return in the future (Sadler and Whitworth, 1975).

A similar study (Lader, 1995) conducted in 1993 and using the 1991 census as its base, found that 311,500 (68 per cent) of those who had qualified to be nurses, midwives or health visitors, were working in nursing (data are for England only).

Of the remainder, 16 per cent were employed in non-nursing work and 15 per cent were economically inactive. Only seven per cent of this 'out-of-service' population had never worked in nursing and around a third of those who were in employment were reported to be in fields which used their nursing skills.

The survey of the 'out-of service' population in 1993 found that nearly a fifth (18 per cent) had returned to nursing since the 1991

[1] Ministry of Health (1947) *Report of the Working party on the recruitment and training of nurses*, HMSO

census (Lader, 1995). A further 14 per cent intended to return in the future. That implies a pool of those genuinely available for nursing employment of little more than 20,000. Most of those in the pool are women with dependent children.

The scope for increasing nursing participation rates appears to be limited. One effect of this is likely to be greater pressure on those currently in the workforce to increase their contracted or actual working hours. We will return to this point in chapter 5 below. Here we present evidence from the membership survey dealing with a number of recruitment issues:

- firstly, we describe the growing use of short-term employment contracts, and discuss their effects on perceptions of job security
- secondly, the extent to which NHS trusts and other employers are facilitating the return to work of nurses with caring responsibilities is described
- thirdly, the extent to which those currently out of nursing employment, and those out of NHS nursing, anticipate future employment in the NHS is explored.

4.2 Results

4.2.1 Short-term contracts

Permanent employment has been the traditional norm in the NHS, with temporary bank and agency nurses being used as an additional 'flexible' component. Employment on short-term contracts has not been common in the past, but is identified by Buchan (1995) as an option increasingly considered by NHS managers in response to the conditions imposed by the internal market and by changing circumstances in the labour market.

Although there are no official data on the distribution of short-term contracts, the NHSE Personnel Director is recently reported to have said that short-term contracts were being over-used by trusts and were contributing to perceptions of job insecurity[1].

IES data confirm the trend. Almost all of the NHS trusts responding to an IES survey in Autumn 1995 were using short-term contracts to employ registered nurses. Over half (54 per cent) had increased their use in the last two years (Buchan, Seccombe and Ball, 1996 forthcoming).

The current survey of RCN members adds further detail to this picture. In 1995 we found that four per cent of all NHS nurses were employed on temporary (*eg* agency or bank) or short-term contracts; in 1996 this figure has increased to five per cent. The

[1] *Health Service Journal*, 26 June 1996

survey suggests some variation by trust type. Seven per cent of nurses in community trusts reported being on such contracts, compared with four per cent of those in non-acute hospitals and five per cent of those in acute hospital trusts.

This data fits closely with the latest (December 1995 to February 1996) Labour Force Survey figures showing just under six per cent of 'qualified' nurses working on non-permanent contracts.

For the first time we are able to distinguish between those nurses on temporary contracts (*eg* bank or agency work) and those on short-term contracts (*eg* three months). The latter account for 70 per cent of respondents on non-permanent contracts.

Further analysis reveals important differences between these two groups. Firstly, that almost two-fifths (38 per cent) of those on short-term contracts are aged under 30, compared with less than one in six (16 per cent) of those on temporary contracts. Secondly, nearly thirty per cent of those on short-term contracts first worked as a registered nurse in the last three years, compared with 20 per cent of those on temporary contracts.

Overall, our evidence suggests that a quarter (24 per cent) of all nurses who joined, or returned to, NHS nursing in the last year, were employed on non-permanent contracts. This proportion varies by trust type, rising from 20 per cent (of joiners) in acute hospital trusts to 33 per cent in community trusts.

As in previous years, we find that newly registered nurses are disproportionately represented among those employed on short-term or temporary contracts. More than a quarter (28 per cent) of those on short-term contracts, and 26 per cent of those on temporary contracts, had registered in the last three years.

Earlier analysis of 'first destination' data from nursing colleges demonstrated that 40 per cent of the 1993 to 1994 qualifiers who were employed in NHS nursing posts, were on temporary or short-term contracts (Seccombe, Jackson and Patch, 1995). In a survey of NHS nurses who qualified in 1994 we found only 38 per cent were employed on permanent contracts (Stock and Seccombe, 1994).

In previous surveys we have found a close relationship between the proportion of nurses on short-term contracts and their year of first registration. In 1995, for example, we noted that 27 per cent of those who first registered in 1994 were on such contracts, compared with 14 per cent who registered in 1993, and seven per cent who registered in 1992, implying that this was a temporary feature and that such nurses would subsequently move on to permanent contracts. This relationship may be weakening.

The 1996 survey shows that similar proportions of those registering in each of the last three years are on short-term

contracts. This implies that nurses may have a succession of short-term contracts over a number of years. Analysis of the length of time which nurses on short-term contracts have been in employment with the same NHS trust appears to confirm this. Almost half (48 per cent) of those on short-term contracts have been with the same employer for more than a year.

The effect which this can have on morale and perceived job security was highlighted by the Review Body in its 1995 report which commented:

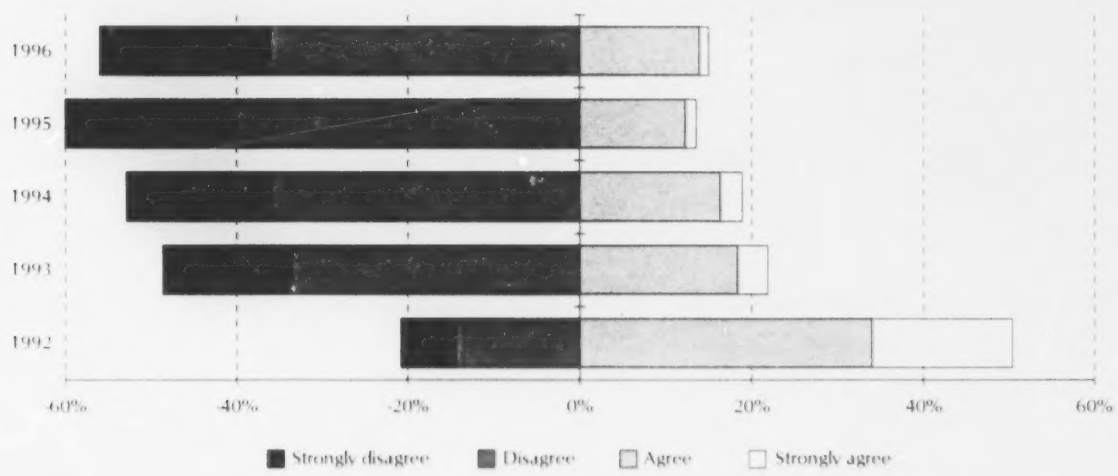
> *'We found in the units we visited that motivation and commitment were frequently high but that staff were anxious about future employment prospects. This was particularly the case where Trusts were making increasing use of short-term contracts for staff, for example to cope with uncertainties caused by Trusts' own short duration contracts with their purchasers. Some Trusts appeared to be using very short-term (eg three month) renewable contracts as a matter of policy, even where posts were expected to continue.' (para. 43)*

The survey data also suggest that the spread of short-term contracts may be associated with a rise in perceived job insecurity. All respondents were asked to indicate the extent to which they agreed or disagreed with the following statement:

> *Nursing will continue to offer me a secure job for years to come*

Overall, only 16 per cent of NHS nurses agreed with the statement, a figure which has declined steadily over the last five years (Figure 4.1), paralleling the introduction of the internal market. Nevertheless, this is a slight increase on 1995 when 14 per cent agreed with the statement. This small turnaround may mark the beginning of a return of confidence, reflecting a rise in vacancy levels and perceived nursing shortages.

Figure 4 : 1 'Nursing will continue to offer me a secure job for several years' — NHS nurses (1992 to 1996)



Source: IES 1996

While 16 per cent of NHS nurses agreed that nursing would continue to offer them a secure job, the comparable figures for non-NHS nurses (27 per cent) and for GP practice nurses (37 per cent) suggest that this is a problem for the NHS in particular.

Within the NHS, there is some variation in the pattern of responses to this statement by trust type, with those nurses in non-acute (long stay) hospital trusts most likely to disagree (60 per cent). This compares with figures of 57 per cent and 54 per cent for community trusts and acute hospital trusts respectively.

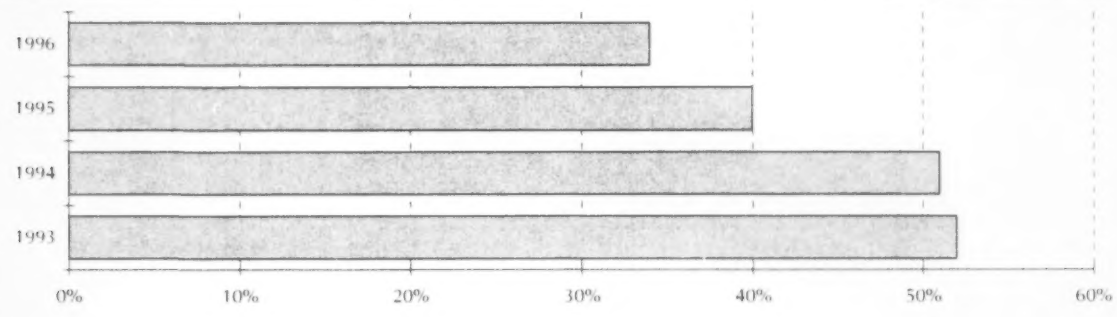
Further analysis shows that concern about job security is heightened among those who are on short-term contracts. Nearly two-thirds (64 per cent) of these nurses felt that nursing would not offer them a secure job, with 29 per cent disagreeing strongly. This compares with 56 per cent of nurses on permanent contracts who were concerned about job insecurity, and 19 per cent disagreeing strongly.

Nurses were also asked to consider a second statement on job security: *'I am worried that I may be made redundant'*.

Overall, just over a third (34 per cent) of NHS nurses agreed that they were worried about being made redundant — a figure out of all proportion with those who have actually been made redundant in the recent past (see section 3.2.1). In practice, the proportion of nurses who report being concerned about being made redundant has reduced steadily since the early 1990s, when there was considerable uncertainty surrounding Tomlinson, the acute sector reviews, and the organisational re-structuring which accompanied the emergence of trusts (see Figure 4.2). The proportion of nurses who gave redundancy as the main reason for their job change has fallen in successive IES/RCN surveys, from five per cent in 1993 to two per cent in 1996.

Concern about redundancy appears to be more widespread among NHS nurses compared with those in other sectors. Only 22 per cent of non-NHS nurses and 18 per cent of GP practice nurses agreed with the statement.

Figure 4 : 2 Proportion of NHS nurses worried about being made redundant, 1993 to 1996



Source: IES 1996

Somewhat paradoxically then, it appears that while concerns about immediate redundancy have receded for many NHS nurses, an increasing proportion see nursing as no longer offering them continuing long-term job security.

The evidence presented in this section suggests several important conclusions:

- firstly, that some trusts are continuing to use short-term contracts as part of their strategy to ensure their labour supply, but without commitment to their employees
- secondly, that the Review Body was correct in its assertion that some trusts appeared to be using renewable contracts as a matter of policy *' ... even where posts were expected to continue.'*
- thirdly, that one of the consequences of short-term contract working is a heightened perception of job insecurity, even among those on permanent contracts.

4.2.2 Recruiting and retaining carers

The majority (51 per cent) of NHS nurses in this survey have caring responsibilities, either for dependent children (41 per cent), dependent adults (16 per cent), or both (six per cent). Of these, nearly half (48 per cent) have pre-school children. Among those who were currently taking a career break, the proportion with dependent children rises to 83 per cent, 89 per cent of whom have pre-school children. Almost two-thirds (62 per cent) of bank nurses have dependent children (46 per cent with pre-school children).

After a number of years in which the NHS had windfall gains from recession, measures to increase the recruitment and retention of nurses are taking on renewed importance. However, most employment practices continue to be designed around the assumption that individuals work full time throughout their lives. The challenge for the NHS is to adopt so-called 'family friendly' employment practices that would make it easier for women or men to maintain their careers in nursing (although recognising that women continue to undertake the major share of carer and domestic responsibilities).

For most women, the family responsibilities which crucially affect their employment are pregnancy and childbirth, care of pre-school children, care of school aged children, and care of dependent adults. Typically, many female nurses have worked full time until they have children, leave employment whilst the children are young, then return to work on a part-time or temporary (bank or agency) basis. As the children grow older, they may eventually return to full-time work. Some then take a second period of part-time or temporary working whilst caring for elderly dependants. A recent survey of newly qualified

nurses shows that these patterns are likely to continue (Marsland *et al.* 1996). The employment practices which nurses need in order to remain in, or return to, permanent employment, vary over this cycle.

The major initiatives adopted by leading edge employers in other sectors to help reduce shortages, to reduce turnover costs and to maximise the potential of their female workforces, fall into three main types:

- promoting opportunities for job-sharing and part-time working
- career break schemes
- childcare support.

Each of these is briefly examined here.

Part-time working and job-sharing

The opportunities for nurses to work part time in the NHS appear to be increasing. More than a third (38 per cent) of trusts responding to an IES survey in Autumn 1995 reported a growth in part-time contracts, and the IES/RCN membership surveys show a rise in part-time working by nurses in the NHS from 29 per cent in 1989 to 35 per cent in 1996. What is not known is the extent to which part-time working is discretionary.

By contrast, job sharing is far less common in NHS nursing. An IMS survey of health authorities and boards in the late 1980s described the limited extent of job-sharing in the NHS, suggesting that there were then only 500 job-share posts and only 200 nurses employed in job-share posts (Meager, Buchan and Rees, 1989). The present survey suggests that the proportion of NHS nurses employed in job-share posts remains comparatively low, at just over one per cent (rising to three per cent among community nurses).

Career break schemes

Although about a quarter of nurses have taken a career break (Jackson and Barber, 1993) few have access to formal career break schemes which allow staff to take, for example, extended maternity leave with the offer of preferential re-instatement or the guarantee of re-employment. Table 4.1 (overleaf) suggests that only one per cent of nurses in the present survey have formal career break schemes.

Childcare support

Childcare continues to be a major challenge for working mothers, and difficulty in obtaining childcare provision may limit nurses' working hours and patterns. After-school and school holiday childcare are particular problems. The survey

Table 4 : 1 Proportion of NHS nurses with caring responsibilities, receiving help from their employer

Type of help	% receiving	Type of help	% receiving
Workplace nursery/crèche	3	Flexible full-time working hours	7
After school hours/holiday playscheme	3	Special shifts (eg twilight)	4
Carers' leave arrangements	6	Job-sharing	1
Financial help with costs (eg childcare allowance/vouchers)	0	Career break or retainer scheme	1

Source: IES 1996

suggests that less than three per cent of nurses with dependent children make use of such schemes and that only four per cent use a workplace nursery or crèche.

Overall, only a minority (20 per cent) of the nurses in this survey report that they received any help from their employer with their caring responsibilities. Table 4.1 (above) shows the proportions of those with caring responsibilities receiving various types of assistance from their employer.

This evidence suggests that comparatively few NHS nurses have access to working arrangements which would enable them to combine work and caring responsibilities more readily. The low incidence of such arrangements, or their low take-up among those in the workplace, suggests that few trusts have effectively adopted employment practices which might reduce wastage, and would satisfy the expectations of those currently out of paid employment who want to return to nursing.

In this regard the NHS is no different to other nurse employers. Respondents in all sectors report similarly limited levels of provision.

Within the NHS there appears to be some variation in the availability of support by work setting. Twenty-two per cent of nurses with caring responsibilities who work in acute and general hospital trusts reported receiving help from their employer, compared with only eight per cent of those in non-acute hospital trusts, and 17 per cent of those in community trusts. However, the number of respondents in these categories is comparatively small and these figures should be interpreted cautiously.

4.2.3 Recruiting from the pool

In this survey, those who were not in NHS nursing were asked what they expected to be doing in two years' time. This 'pool' includes both those who are currently working in nursing but outwith the NHS, those who are working outside nursing, and

Table 4 : 2 Anticipated employment status in 1998 of nurses currently outwith NHS nursing

Anticipated employment status	Non-nursing %	Career break %	Non-NHS nursing %
An NHS nursing job	8	31	5
The same non-NHS nursing job	10	–	48
A different non-NHS nursing job	8	15	26
A non-nursing job	45	25	7
Break from work	3	21	2
Retired	8	2	5
Other	18	6	7
Base number	*38*	*48*	*515*

Source: IES 1996

those not currently in paid employment. Note that the number of respondents in the latter two categories is rather small.

Table 4.2 shows the anticipated employment status in 1998 of those currently in non-nursing employment, on career breaks, or in non-NHS nursing jobs.

These data suggest that non-NHS nursing and non-nursing employment are unlikely to be pools from which the NHS can recruit registered nurses, at least in the short term. Only five per cent of non-NHS nurses anticipated working in the NHS in two years' time, which is similar to the actual flow between these two sectors reported earlier (section 3.2.5) during 1995 to 1996.

We saw earlier that a high proportion of those who left nursing cited job dissatisfaction as their reason for leaving. This finding accords well with the OPCS study which indicates that 43 per cent of those who were currently working outside nursing, did not intend to return because of dissatisfaction with the profession or preference for other employment.

Just under half the respondents (46 per cent) who were currently taking career breaks anticipated a return to nursing within the next two years, 31 per cent to the NHS. Measures which would attract such nurses back into the profession, according to the OPCS study, included: refresher courses including updating in recent developments; return to nursing programmes, greater availability of part-time work, more flexible working hours or job-sharing; more opportunities for developing skills and re-training in different specialist fields, more patient contact and better resources; and provision of crèches/day care for young children. The evidence from this survey suggests that comparatively few will find these expectations satisfied.

4.3 Key findings

The key findings reported in this chapter include:

- Five per cent of all NHS nurses were employed on short-term or temporary contracts; this figure rises to seven per cent among those in community trusts.
- A quarter of those nurses who joined (or returned to) NHS nursing in the last year, were employed on non-permanent contracts.
- The widespread use of short-term contracts is associated with an increase in perceived job insecurity, even among those on permanent contracts.
- Forty-one per cent of NHS nurses have caring responsibilities for dependent children, and 16 per cent for dependent adults; only 20 per cent report having 'family friendly' policies which enable them to combine work and caring responsibilities more readily.
- The survey suggests that few trusts have effective employment practices to help those 'carers' who want to return to nursing.
- Comparatively few of the nurses in non-NHS nursing (five per cent) or in non-nursing employment (eight per cent) anticipated a return to NHS nursing in the next two years.

5. Working Hours and Workloads

5.1 Introduction

If the scope for increasing nursing participation rates is limited as discussed in the previous chapter, then individual nurses may come under pressure to increase their own activity by working more hours, in the attempt to make up for the shortage.

However, the European Union Working Time Directive is due to take effect from 23 November 1996. If the Directive is implemented in the NHS it will have a profound impact. The Directive aims to cut excessively long working hours and provide protection for night and shift-workers. It specifically requires the following[1]:

- a maximum 48 hour working week including overtime averaged over a four month period
- a maximum eight hours for night shifts in a 24 hour period
- a rest period after six hours' consecutive work
- a minimum daily rest period of 11 consecutive hours
- a weekly rest period of 24 hours, consecutive with the 11 hour daily rest period
- a minimum of four weeks paid leave.

The UK government has challenged the legality of the Directive on the grounds that working time is not a health and safety issue. However, a study of sickness absence in nursing (Seccombe and Buchan, 1993), found higher rates of absence among nurses whose perceived workload was higher. Results recently published by the Institute of Work Psychology (Borrill *et al.*, 1996) lead the authors to conclude that: *'higher levels of mental ill-health recorded by female managers, nurses and doctors compared with their female colleagues in the other occupations are strongly associated with higher perceived work demands'*. Earlier (see 3.2.4) we presented evidence which suggests that an increasing proportion of nurse turnover and wastage are related to work-place injury and ill-health.

[1] IDS Employment Europe, (403) November 1995.

Three-quarters of respondents in a national survey of nurse executive directors in NHS trusts (Seccombe, Buchan and Ball, forthcoming, 1996) reported that improving continuity of care, improving flexibility of deployment, and improving the match of staffing to workloads were very important factors in changing deployment patterns. Two-fifths identified reducing shift overlap and improving recruitment and retention as very important factors.

This chapter discusses the working hours and workloads of respondents in light of the labour market trends described earlier, and the forthcoming Directive. It is arranged as follows:

- the pattern of full-time and part-time working of NHS and non-NHS nurses is described (section 5.2.1)
- variations in shift patterns for NHS and non-NHS nurses are examined (section 5.2.2)
- length of shifts worked by NHS and non-NHS nurses are considered (section 5.2.3)
- rest periods are examined (section 5.2.4)
- the number of consecutive hours of off-duty worked by NHS and non-NHS nurses is provided (section 5.2.5)
- evidence of excess hours working by nurses is presented (sections 5.2.6)
- the extent to which nurses undertake additional paid work is examined (section 5.2.7)
- nurses' perceived workloads are examined (section 5.2.8).

5.2 Results

5.2.1 Part-time working arrangements

Nearly two-thirds (60 per cent) of all respondents currently working in nursing reported working full time. This is the same as the figure given by the most recent Labour Force Survey (December 1995 to February 1996). Table 5.1 shows the distribution of job hours by employment sector. There did not appear to be much variation between NHS and non-NHS nurses

Table 5 : 1 Pattern of job hours, by employment sector

Employment Sector	Full-time	Part-time	Job-share/ Occasional	Base no.
	%	%	%	
NHS nursing	64	35	1	2,881
Non-NHS nursing	62	36	2	513
GP practice nursing	19	77	4	301

Source: IES 1996

Table 5 : 2 Average number of weekly contracted hours for part-time nurses, by employment sector

Employment sector	Contracted hours mean (s.d.)		Base no.
NHS nursing	23.7	(6.3)	985
Non-NHS nursing	22.3	(7.3)	175
GP practice nursing	21.5	(6.5)	227
All respondents	*23.1*	*(6.7)*	*1,428*

Source: IES 1996

in terms of job hours. The proportion of NHS and non-NHS nurses working full time has decreased slightly. Sixty-six per cent of NHS nurses worked full time in 1995 compared with 63 per cent in 1996. The figures for non-NHS nurses were 64 and 62 per cent respectively. Despite a small increase in the proportion of GP practice nurses who reported working full time (from 15 per cent in 1995 to 19 per cent in 1996) the majority (77 per cent) worked part time.

Part-time respondents also reported variation in the number of weekly contracted hours. Part-time NHS nurses were contracted to work slightly more than nurses in the other two employment sectors. Table 5.2 (above) shows the average (mean) number of contracted hours (and the standard deviation) worked by part-time respondents in the three main employment sectors.

The proportion of nurses working full time and part time by age is remarkably similar, in both NHS and non-NHS employment. The majority (84 per cent) of NHS nurses aged between 20 and 29 years worked full time compared with, for example, 56 per cent of NHS nurses aged 30 to 39 years. Part-time working among the latter is associated with having dependent children.

A third (36 per cent) of full-time NHS nurses, aged 30 to 39 years, had dependent children, compared with 62 per cent of those working part time.

A higher proportion of older nurses work part time in the non-NHS sector. For example, a fifth of non-NHS nurses aged 40 to 49 years reported working part time, compared with 12 per cent of NHS nurses in the same age group.

5.2.2 Shift patterns

There was wide variation in shift patterns reported by respondents. Table 5.3 (overleaf) shows the distribution of shift patterns for NHS and non-NHS nurses. A third (32 per cent) of NHS nurses work a three shift system (internal rotation of early, late and night shifts) compared with a fifth (12 per cent) of non-NHS nurses.

Table 5 : 3 Shift patterns, by employment sector

Shift pattern	NHS nursing	Non-NHS nursing
Internal rotation	32%	12%
Earlies & late shifts	21%	39%
Nights only	11%	15%
Day-time (office hours)	26%	22%
12 hour shifts	5%	4%
Other	5%	8%
Base number	*2,970*	*511*

Source: IES 1996

Earlier IES/RCN surveys found substantially fewer respondents working a three shift system, for example, only 22 per cent of NHS nurses reported working internal rotation in 1990. Three shift systems were also found to be the most prevalent shift pattern in a recent survey of NHS trusts; 13 per cent of trusts reported increased use of the three shift system over the past two years (Buchan, Seccombe and Ball, 1996, forthcoming).

Internal rotation is generally regarded as unsociable and family unfriendly as working patterns change rapidly within the three shift system. A large minority (47 per cent) of NHS nurses on internal rotation reported in the 1995 survey that internal rotation was not their desired shift pattern. Despite this, the prevalence of internal rotation has risen, even amongst NHS nurses with dependent children or other caring responsibilities (from 26 per cent in 1995 to 28 per cent in 1996).

Shift patterns also varied by work setting. For example, 71 per cent of NHS community nurses reported working nine to five compared with 12 per cent of NHS hospital (acute and non-acute) based nurses. Permanent night shifts were less common with only 12 per cent of NHS hospital based nurses, and two per cent of NHS community nurses, deployed in this way. There has also been a slight fall in the overall proportion of NHS nurses who reported working permanent nights, from 13 per cent in 1992 to 11 per cent in 1996.

The national survey of nurse executive directors (Seccombe, Buchan and Ball, 1996, mentioned above) reported that two-fifths of trusts used a 12 hour shift system. Nationally, the proportion of nurses working 12 hour shifts is unknown, although it is reported to be increasing. This accords with evidence from previous IES/RCN surveys showing that the proportion of NHS nurses working 12 hour shifts is increasing yearly, albeit slowly. Among non-NHS nurses the proportion who reported working 12 hour shifts has fluctuated between two and three per cent each year. Table 5.4 (overleaf) shows the proportion of nurses working 12 hour shifts in the NHS and non-NHS since 1993.

Table 5 : 4 Proportion of nurses working 12 hour shifts, 1993 to 1996

Year	NHS %	Base no.	Non-NHS %	Base no.
1993	2	2,158	3	603
1994	2	2,028	2	350
1995	3	2,916	2	499
1996	5	2,874	3	511

Source: IES 1996

5.2.3 Shift hours

Respondents were asked to indicate the length of their last shift including any rest period. There was great variation amongst NHS nurses but the median length was eight hours.

Reported shift lengths ranged from three hours to 28.5 hours. Part-time nurses frequently worked shorter shifts, perhaps reflecting the greater flexibility of part-time working. The extreme shift lengths were reported by nurses who undertook 'sleep-in' and 'on-call' duties. Two per cent of nurses who responded to this question reported working more than 13 hours in the reference period (this may be atypical of their average working day). Enforcement of the Directive would mean that shifts should not, on average, exceed 13 hours. The average shift length for both NHS and non-NHS nurses was 8.9 hours.

The Directive also specifies a maximum length of eight hours for night shifts. Reported night shifts ranged between 8.25 hours and 12.5 hours for all nurses. The average night shift length was 10.6 hours for all NHS nurses and 11.1 hours for all non-NHS nurses.

No significant variation in shift length was reported by NHS nurses working full time in hospitals (acute and non-acute) or the community, but there was variation by field of practice. Table 5.5 (below) shows the average length of last shift by field of practice for full-time NHS nurses. Paediatric nurses worked, on average, the longest shifts. Nurses working in paediatrics and acute adult fields worked longer shifts than nurses in the fields of mental health and elderly care.

Table 5 : 5 Average length (hours) of last shift worked by NHS nurses, by field of practice

Field of practice	mean	(s.d.)	Base no.
Acute adult	9.0	(1.8)	736
Primary care	8.4	(0.8)	29
Paediatrics	9.3	(1.9)	112
Mental health	8.7	(1.9)	95
Elderly care	8.4	(1.2)	121
All respondents	*8.9*	*(1.9)*	*1,319*

Source: IES 1996

There was little variation between reported shift patterns and shift length. The notable exception was the average length of night shifts. Full-time nurses worked on average 10.8 hours for night shifts, compared with 8.7 hours for internal rotation.

5.2.4 Rest periods

Enforcement of the Directive would ensure entitlement to a rest period where the working day exceeds six hours. On average, NHS nurses who worked a minimum of six hours on their last shift, worked three hours before having a rest period. Eighteen per cent of NHS nurses (and 19 per cent of non-NHS nurses), reported that they did not have a rest period.

The Directive specifies a minimum rest period of 11 hours per working day. The number of hours off reported by nurses varied from zero hours to seven days. Table 5.6 (below) shows the number of reported hours off between shifts, by employment sector. A large minority (40 per cent) reported having less than 11 hours off between their last two shifts. More than 95 per cent of NHS respondents who had less than 11 hours off between their last two shifts were deployed on internal rotation or early/late shifts. The comparable figure for non-NHS nurses is 86 per cent.

5.2.5 Worked hours

Respondents were asked to indicate the number of hours of consecutive off-duty worked in their main job during the last full working week. Consecutive off-duty refers to the number of hours spent at work, each week, including any rest periods. The response rate to this question was only 45 per cent, and therefore interpretation of results should be treated with caution.

The number of hours worked by all NHS nurses ranged from 0.5 hours to 96 hours, with an average of 35 hours. Clearly some nurses (14 per cent) are working in excess of the 48 hour maximum working week specified by the Directive. However, this may have been an atypical working week for some of these nurses, and it may be that working weeks, averaged out over four months, do not exceed 48 hours.

Full-time NHS nurses worked an average of 39.4 hours compared to 37.9 hours for non-NHS nurses. Part-time NHS nurses worked an average of 25.2 hours compared to 23.4 hours

Table 5 : 6 Number of hours off between last two shifts, by employment sector

Employment sector	< 11 hrs %	11-24 hrs %	1-2 days %	2+ days %	Base no.
NHS nursing	40	46	7	7	760
Non-NHS nursing	23	53	10	14	341

Source: IES 1996

for non-NHS nurses. In both cases this is marginally more than the average weekly contracted hours (see section 5.2.1 above).

Overall, three-fifths (60 per cent) of respondents worked 37.5 hours or less of consecutive off-duty in their last full working week. The total number of hours worked varied across employment situations. Nearly all (90 per cent) GP practice nurses reported working 37.5 hours or less, which is consistent with the large proportion who work only part time.

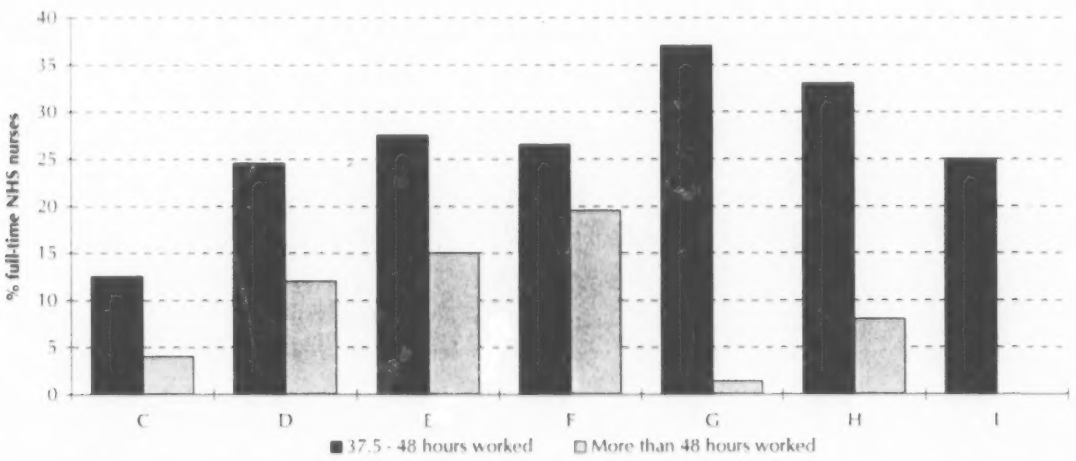
More than half (55 per cent) of the NHS nurses working full time reported working more than 37.5 hours in their last full working week. A fifth (19 per cent) of these NHS nurses worked more than 48 hours in their last week, compared to ten per cent in 1995. The figures are similar for full-time non-NHS nurses; 54 per cent reported working more than 37.5 hours, while 15 per cent reported working more than 48 hours (figures were the same as in 1995).

There was no variation in the number of consecutive hours of off-duty worked by NHS nurses in hospital or community settings. There was, however, more variation by clinical grade. For example, one in five full-time F grade NHS nurses reported working more than 48 hours in the last week, compared with one in ten D grade NHS nurses. Figure 5.1 shows the proportion of NHS nurses (full time only) who worked more than 37.5 hours in the last week, by clinical grade.

5.2.6 Excess hours

More than half of the respondents report that they worked in excess of their contracted hours in their last full working week. The number of excess hours worked in the main job, for all nurses, ranged from one hour to 50 hours, with an average value

Figure 5 : 1 Number of hours worked in excess of 37.5 hours by full-time NHS nurses, by clinical grade



Source: IES 1996

Table 5 : 7 Proportion of nurses who worked excess hours, by employment sector

Employment sector	%	Base no.
NHS nursing	59	2,854
Non-NHS nursing	50	494
GP practice nurse	52	298

Source: IES 1996

of 6.2 hours. The proportion of NHS nurses who reported working in excess of their contracted hours is similar (59 per cent) to the 61 per cent reported in the 1995 survey. Table 5.7 (above) shows that excess hours working is more prevalent among NHS nurses than elsewhere.

The number of excess hours worked varied by employment sector. Nurses working in excess of contracted hours, on the whole, worked five hours or less: 62 per cent of NHS nurses and 48 per cent of non-NHS nurses. Nearly a third (30 per cent) of non-NHS nurses worked in excess of ten additional hours in their last full working week, compared with a fifth (13 per cent) of NHS nurses.

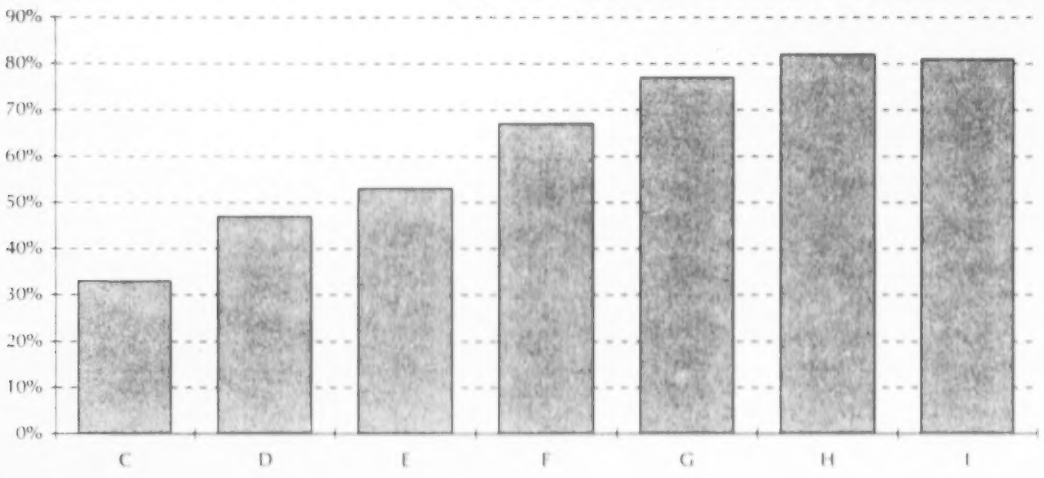
The average number of excess hours worked by individual nurses nearly doubled, from an average of 3.7 hours in 1995 to 5.9 hours in 1996. Non-NHS nurses reported the greatest increase in excess hours working, from an average of 4.3 hours in 1995 to 7.9 hours in 1996. NHS nurses reported an increase from 3.8 hours in 1995 to 5.9 hours in 1996.

NHS nurses on the higher clinical grades were more likely to report excess hours working than their counterparts on the lower end of the clinical scale. For example, three-quarters (78 per cent) of G grade nurses reported working in excess of their contracted hours, compared with half (48 per cent) of D grade nurses (Figure 5.2 overleaf).

As stated previously, the average number of excess hours worked was 5.9 hours, but again it varied by clinical grade. D grade nurses reported on average working an excess of 4.6 hours, compared with 5.7 hours for E grades nurses, 6.1 hours for F and G grade nurses, and 7.8 hours for H and I grade nurses.

Earlier (Chapter 4) we suggested that the scope for increasing the labour market participation of nurses was limited. It is likely, therefore, that there would have to be an increase in activity levels of those nurses already participating in the labour market to match demand. The sum total of excess hours worked by NHS and non-NHS nurses has increased over the past year (see Table 5.8). NHS nurses working excess hours, reported a 39 per cent increase in the number of excess hours worked, which was equal to a sixth of their contracted hours. The total excess hours worked was a tenth of the contracted hours for all NHS respondents.

Figure 5 : 2 Proportion *of NHS nurses, by clinical grade, working in excess of contracted hours*



Source: IES 1996

Table 5.8 (below) also shows the different types of remuneration which nurses received for excess hours worked. Overall there has been a decline in the proportion of NHS nurses who report receiving payment for excess hours (from 34 to 27 per cent).

Data for the number of hours of meal breaks worked through were last reported in the 1991 IES/RCN survey (Buchan and Seccombe, 1991). Thirty six per cent of NHS nurses reported working through meal breaks in 1991, compared with thirty per cent this year. The average number of hours (*ie* meal breaks worked through) has also declined from 2.4 hours in 1991 to 1.3 hours in 1996.

A greater proportion of NHS community nurses (69 per cent) reported working in excess of their contracted hours, compared with 58 per cent of NHS nurses in acute and non-acute hospitals. Table 5.9 (overleaf) compares the different types of remuneration of community and hospital NHS nurses for excess hours worked.

There was little variation in the number of excess hours worked by NHS nurses in different work settings. The average number of excess hours worked by nurses in acute/general hospitals was 5.6 hours, compared with 6.1 hours in the community. However, the proportion of those hours which were paid is much lower (12 per cent) in community settings.

Table 5 : 8 Remuneration for excess hours, by employment sector, 1996 (1995 figures in brackets)

Employment Sector	Paid %		Unpaid %		Time in lieu %		Total excess hours	
NHS nurses	27	(34)	23	(35)	28	(31)	9,191	(5,593)
Non-NHS nursing	33	(50)	23	(26)	31	(24)	1,720	(1,262)

Source: IES 1996

Table 5 : 9 Remuneration for excess hours, by main work setting, 1996 (NHS nurses only)

Work setting	Paid	Unpaid	Time in lieu	Meal breaks worked	Total excess hours
	%	%	%	%	
Hospital	32	21	28	19	6,179
Community	12	29	28	31	1,982

Source: IES 1996

5.2.7 Additional working

In 1996, a quarter (26 per cent) of NHS nurses reported doing paid work in addition to their main job, compared with 17 per cent in 1991. Table 5.10 (below) shows the proportion of NHS nurses under-taking different types of additional paid work.

Bank nursing was predominant. More than twice as many NHS nurses report working on the 'bank' in addition to their main job in 1996 (50 per cent) than in 1995 (23 per cent). The increase in bank nursing in addition to main employment may be one strategy by which trusts meet growing demand for nurses. For individuals, as we saw in the last section, it may also provide guaranteed remuneration for extra hours worked, where in the past they might have worked paid overtime.

The average number of bank hours worked each week by NHS nurses has also risen, from 7.7 hours in 1995 to 8.8 hours in 1996.

The proportion of NHS nurses who undertake additional paid work declined with increasing age, from 39 per cent of nurses aged 20 to 24 years, to eight per cent aged 55 to 59 years. A slightly higher proportion of part-time nurses (28 per cent) did additional paid work compared with full-time nurses (25 per cent). The usual number of hours worked in the additional job were reported to range between one hour and 39.5 hours, with an average of nine hours per week.

5.2.8 Workload stress

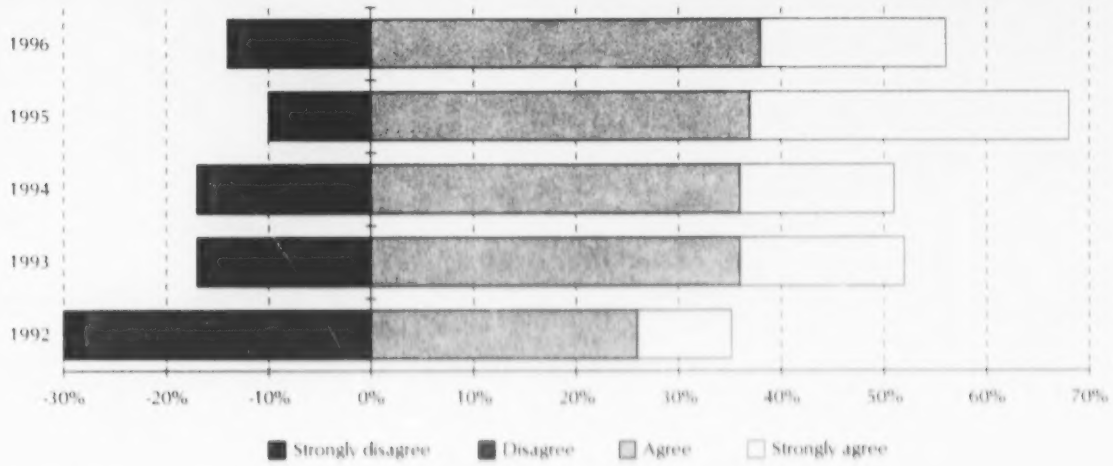
In the remainder of this chapter nurses' perceptions of, and attitudes towards, workloads are discussed. Respondents were

Table 5 : 10 Types of additional paid work of NHS nurses

Type of Additional Work	NHS nurses	
	%	Base no.
Additional NHS nursing	9	71
Agency nursing	20	168
Bank nursing	50	416
Non-NHS nursing	13	103
Non-nursing	8	68

Source: IES 1996

Figure 5 : 3 'I feel I am under too much pressure at work', 1992 to 1996 — NHS nurses only



Source: IES 1996

asked to indicate the extent to which they agreed or disagreed with a number of attitudinal items about working life. A distinct cluster of items emerged concerning satisfaction with workloads. The scale allows perceived workloads to be compared for a number of variables (see Appendix C).

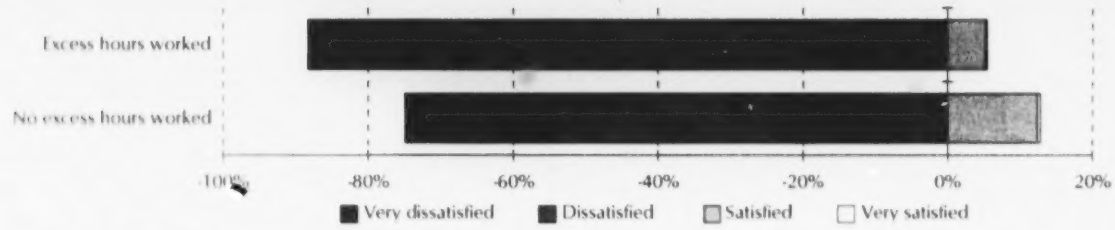
The workload scale included the following items:

- *my workload is too heavy*
- *I have to work very hard in my job*
- *I feel I am under too much pressure at work.*

The third item of the workload scale *'I feel I am under too much pressure at work'* has been included in each of the past five surveys. Figure 5.3 (above) shows the response of NHS nurses to this statement over the past five years. There is an increase in the proportion of NHS nurses who report feeling *'under too much pressure at work'*. A third (35 per cent) of NHS nurses in 1992 agreed or strongly agreed with the statement. In 1996 the majority (56 per cent) agreed or strongly agreed, but the proportion who neither agreed nor disagreed increased from 22 per cent in 1995 to 31 per cent this year. The trend is similar for non-NHS nurses.

Section 5.2.6 above revealed that a marginally smaller proportion of NHS nurses were working excess hours, but that the average number of excess hours had increased. A greater proportion of NHS nurses (42 per cent) who worked in excess of their contracted hours scored more negatively on the workload scale, that is they had greater perceived workloads, than NHS nurses who did not work excess hours (see Figure 5.4 overleaf). Furthermore, a higher proportion of NHS nurses working in

Figure 5 : 4 Satisfaction with workloads (NHS nurses)



Source: IES 1996

excess of ten hours scored negatively on this scale, than did NHS nurses working less than five excess hours.

Comparison of the perceived workloads of non-NHS nurses working in excess of contracted hours, with those not working excess hours, reveals a similar pattern to that of NHS nurses. However, a higher proportion (88 per cent) of NHS nurses who worked excess hours scored negatively on the workload scale, compared with 78 per cent of non-NHS nurses who worked excess hours.

Overall, 82 per cent of NHS nurses were dissatisfied with perceived workloads. Perceived workloads did not vary for NHS nurses across main work settings, with 80 per cent of both hospital and community nurses scoring negatively. A slightly higher proportion of community nurses (12 per cent) scored positively on the workload scale than hospital nurses (nine per cent), that is they were more satisfied with the perceived workload. Perceived workloads of NHS nurses also varied by job title but not by clinical grade. A third (31 per cent) of staff nurses scored negatively, compared with 44 per cent of sisters or charge nurses.

The relationship between perceived workloads and intention to stay in nursing gives some indication of morale within the workforce. Nearly half (45 per cent) of NHS nurses who scored negatively on the workload scale (dissatisfied with perceived workload) strongly agreed with the statement: *'I would leave nursing if I could'*. Secondly, the greater the perceived workload, the more unlikely it is that NHS nurses would recommend nursing as a career. Only a fifth of NHS nurses who were dissatisfied with perceived workload agreed with the statement: *'I would recommend nursing as a career'*.

5.3 Key findings

The key findings presented in this chapter include:

- Internal rotation was the most prevalent shift system worked by NHS nurses.
- The proportion of NHS nurses working 12 hour shifts has increased over the last five years.

- The average length of last shift reported by NHS nurses was 8.9 hours and varied by field of practice.
- One in five NHS and non-NHS nurses reported that they did not have a rest period during their last shift.
- A large minority of NHS nurses had less than eleven hours off between their last two shifts.
- More than half of full-time NHS nurses worked in excess of 37.5 hours in their last full working week.
- The proportion of full-time NHS nurses working in excess of 48 hours per week has increased by ten per cent this year.
- The average number of excess hours worked by individual NHS nurses has increased by an average of two hours, from 3.8 hours in 1995.
- Fewer NHS nurses received paid remuneration for excess hours worked.
- The proportion of NHS nurses doing additional bank work has doubled in one year.
- Over half of NHS nurses *'feel under too much pressure at work'*.
- The majority of NHS nurses were dissatisfied with perceived workloads.
- Forty-five per cent of NHS nurses who were dissatisfied with perceived workloads would leave nursing if they could while four out of five would not recommend nursing as a career.

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Appendix A: The 1996 RCN Membership Survey

A.1 Aims and objectives

The main aim of this series of surveys is to:

- collect independent quantitative data from a representative sample of registered nurses, which describes their labour market and employment characteristics.

Specific objectives of the 1996 survey were:

- to collect and analyse biographical, employment and career data from a sample of qualified nurses, to contribute to the debate on recruitment and retention
- to collect and analyse data on nurses' pay satisfaction
- to examine the level and characteristics of nurse turnover and wastage
- to consider aspects of nurses' motivation and morale
- to collect and analyse data on nurse's shift patterns, working hours and workloads
- to examine various issues relating to manual handling[1].

A.2 Previous IES surveys

This is the eleventh national survey of registered nurses of the RCN membership to be conducted by the Institute since the mid-1980s. Appendix B contains a full list of the previous survey reports.

These surveys constitute a unique national database of information on the changing employment patterns, careers and attitudes of registered nurses. As such they chart changes in the nursing labour market, and give an insight into the attitudes and responses of nurses to these changes. Where appropriate, this report draws on these earlier surveys to describe trends.

[1] Subject of a future report

A.3 Questionnaire design and piloting

Questionnaire design for this survey followed preliminary discussions with staff in the RCN Labour Relations Department and drew on the Institute's experience of conducting previous national surveys of registered nurses. In order to ensure comparability, much of the content remained unchanged from the 1995 survey.

The 1995 survey was comprehensively piloted; piloting for the 1996 questionnaire could therefore be streamlined. Two groups of registered nurses were asked to complete the questionnaire and then to take part in a group discussion which focused on the new questions. These two groups were:

- a cross-section of nurses working in a large acute hospital trust in the West Midlands
- a cross-section of hospital, community and non-NHS nurses attending an RCN branch meeting in South East England.

In addition to this formal piloting, RCN stewards and professional officers were also invited to comment on the draft questionnaire.

A.4 Sample size and structure

A random sample of 6,000 registered nurses was selected from the RCN's membership records. Like previous samples, only those paying the full membership fee were eligible for selection. The membership categories excluded were: Students; Overseas; Associates; Life and Founder members.

A.5 Response rates

The final version of the questionnaire was sent to the home addresses of those selected in late March, with a covering letter from the General Secretary and a reply-paid envelope.

A reminder letter, a second copy of the questionnaire and a reply-paid envelope were sent to non-respondents after three weeks. By the close of the survey in mid-May, 4,521 completed questionnaires had been returned. A further 173 were returned after the closing date. This represents a crude response rate of 79 per cent.

Details of the mailing and response are given in Table A.1 (overleaf). The high useable response rate of 73 per cent is very satisfactory and means that we can be confident in drawing inferences from this survey population.

Table A : 1 Survey mailing and response

Questionnaires mailed out	6,000
Returned by Post Office	39
Returned as inappropriate	7
Total sample	5,954
Questionnaires returned	4,521
Non-participants	1
Late responses	173
Questionnaires available for analysis	4,347
Overall response rate	4,695/5,954 = 79%
Useable response rate	4,347/5,954 = 73%

Source: IES

Appendix B: IES/RCN Membership Survey Reports

Seccombe I, Patch A, (1995), *Recruiting, Retaining and Rewarding Qualified Nurses in 1995*, Institute for Employment Studies, Report No. 295.

Seccombe I, Jackson C, Patch A (1995), *Nursing: The Next Generation*, Institute for Employment Studies, Report No. 274

Seccombe I, Patch A, Stock J (1994), *Workloads, Pay and Morale of Qualified Nurses in 1994*, Institute of Manpower Studies, Report No. 272

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Appendix C: The Workload Scale

This scale comprises attitudinal items which attempt to measure perceived workloads. Table C1 lists the three items as they appeared in the questionnaire, and their correlation coefficients. The correlation coefficients indicate the degree of relationship between the items and the scale. The closer to unity (*ie* one), the stronger the relationship between the items and the scale. The summary statistics of the scale are given, together with the alpha reliability score which is a measure of the internal reliability of the scale. Figure C1 shows the distribution of scores on the scale.

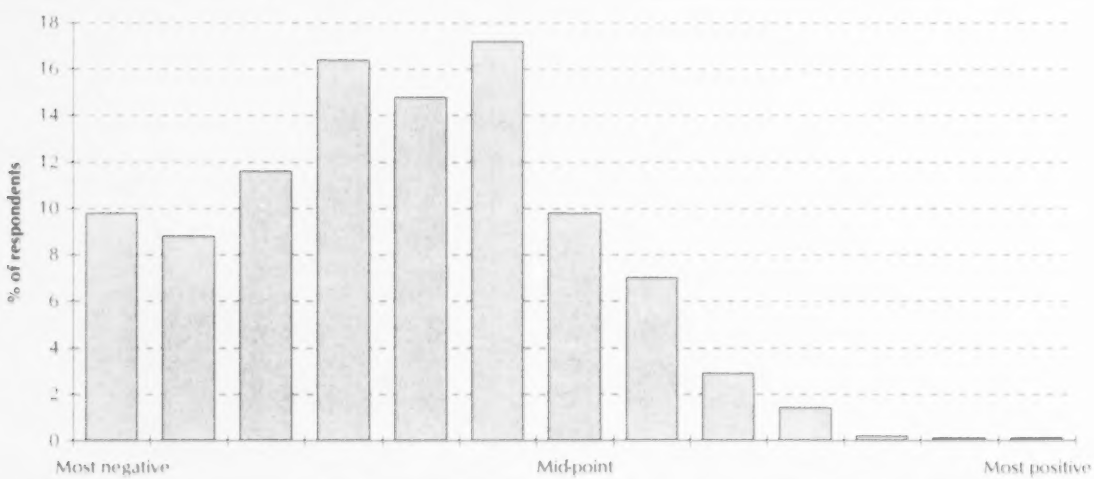
Table C : 1 Items in the workload scale

No.	Statement	Correlation coefficients
7	*My workload is too heavy*	0.80
9	*I have to work very hard in my job*	0.71
12	*I feel I am under too much pressure at work*	0.77

mean score:	**2.24**	**sd:**	**0.75**
min score:	1.00 (most negative)	alpha reliability:	0.76
max score:	5.00 (most positive)		

Source: IES 1996

Figure C : 1 Distribution of scores of workload scale



Source: IES 1996

In the Balance: Registered Nurse Supply and Demand, 1996

The Institute for Employment Studies

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